RCMP PUBLIC COMPLAINTS COMMISSION

CHAIR'S FINAL REPORT

PURSUANT TO SUBSECTION 45.46(3)

FOLLOWING A PUBLIC INTEREST INVESTIGATION

PURSUANT TO SUBSECTION 45.43(1)

INTO THE CHAIR'S COMPLAINT RESPECTING MR. KIM ERIK NIELSEN

October 30, 2000

File No.: 2000-PCC-981276

CHAIR'S FINAL REPORT FOLLOWING

A PUBLIC INTEREST INVESTIGATION

I. INTRODUCTION

The Process

As Chair of the RCMP Public Complaints Commission (hereinafter "the Commission"), I have the authority to initiate a complaint, pursuant to subsection 45.37(1) of the *RCMP Act* (hereinafter "the *Act*"), where I am satisfied that there are reasonable grounds to investigate the conduct, in the performance of any duty or function under the *Act*, of any member or other person appointed or employed under the authority of the *Act*.

When I consider it advisable in the public interest, I also have the authority, pursuant to subsection 45.43(1) of the *Act*, to investigate a complaint, whether or not the complaint has been investigated, reported on or otherwise dealt with by the RCMP. Upon completion of the investigation, I am required to prepare and send a report to the Solicitor General of Canada and the RCMP Commissioner (hereinafter "the Commissioner"), setting out such findings and recommendations with respect to the complaint as I see fit (my "Interim Report").

Upon receipt of the Interim Report, the Commissioner is required to review the complaint in light of the report's findings and recommendations. The Commissioner must then notify me of any further action that has been, or will be, taken with respect to the complaint or provide his reasons for not acting on the findings or recommendations (the "Commissioner's Notice"). After I have considered such a Notice, a Final Report is prepared.

The Interim Report and Commissioner's Notice

On September 21, 1998, I initiated the complaint into this matter, the details of which are found in the Interim Report. Shortly after the initiation of this complaint, the Commission commenced its public interest investigation.

The Interim Report, dated February 17, 2000, was sent to the Solicitor General of Canada and to the Commissioner (Appendix I). The Commissioner responded to the Interim Report by way of a letter dated June 21, 2000 (Appendix II).

The Interim Report includes a complete summary of the evidence collected during the investigation. However, additional information pertaining to the RCMP Cadet Training Program was provided to the Commission after receipt of the Commissioner's Notice, and has therefore been reviewed for the purposes of this Final Report.

II. FINDINGS AND RECOMMENDATIONS OF THE CHAIR

1. General Findings

I am generally pleased with the Commissioner's response to my Recommendations in this case. I note the commitment to the implementation of all the Recommendations on a timely basis and I will follow their implementation with interest.

2. Final Findings

Turning to the Commissioner's specific comments, I report as follows.

My Findings No. 1 to 11: The Commissioner agrees with these Findings, therefore no further comment is necessary.

My Finding No. 12:

> *12. If Mr. Nielsen had received urgent medical attention when detained, which was approximately four hours before his cardiopulmonary arrest, it is possible that he may have survived this episode of acute alcohol intoxication combined with cocaine use.*

I have considered the comments of the Commissioner and reiterate my Finding No. 12. I cannot agree with the Commissioner's view that "comment with respect to this issue is best left to the medical profession." An assessment of Mr. Nielsen, conducted by a member of the medical profession, should have been done. Indeed, if this had been done, in accordance with the RCMP policy and the facts, it is **possible** that he **may** have survived this episode. It was not done and we will therefore never know for sure if this life could have been saved. Regardless, my Finding was meant to emphasize the importance of training members to **recognize** the need to obtain a medical assessment or assistance in certain circumstances. In addition, I emphasize the need to ensure that members, and the guards under their supervision, err on the side of caution when dealing with persons who are intoxicated and/or under the influence of drugs.

My Findings No. 13, 14, 15, and 16: The Commissioner agrees with these Findings, therefore no further comment is necessary.

My Finding No. 17:

> *17. The policy in place dealing with medical assistance for detainees at the time of this incident was not well understood nor well implemented by Constable Bes because, as he indicated, when interviewed by the Commission Investigator, the*

policy dealing with "questionable consciousness" was made available to him but was not accompanied by any instructions or clarification.

I have considered the comments of the Commissioner and reiterate my Finding No. 17. I also restate my concern at the continued and widespread failure to understand and implement the policy dealing with medical assistance for detainees. (See the reports on Public Hearings into the complaints of Donald J. Robinson, Beverley M. Farewell, T. Farewell, R. Robinson and N. Robinson, February 25, 1991, and Donna Wilson, March 1, 1998.)

I find the Commissioner's response to be unclear, particularly in light of his concurrence with Findings 5, 7 and 8.[3] As such, I am unable to determine whether the Commissioner agrees or disagrees with Finding No. 17. Clearly, Findings 5, 7 and 8 support the finding that the policy dealing with medical assistance for detainees, in effect at the time of this incident, was not properly understood or implemented. The Commissioner has concurred that Mr. Nielsen was found to be in a state of "questionable consciousness" while in Constable Bes's custody and that according to RCMP policy, medical attention is mandatory in such cases. In addition, the Commissioner has agreed that a properly trained officer should have recognized the signs of acute alcohol poisoning, in combination with the evidence of recent drug ingestion, and the consequent need to secure prompt medical attention. The logical conclusion is therefore that it is the manner in which the policy is currently being implemented and understood that is problematic. Therefore, it is not enough to state that it is the responsibility of the detachment commanders to ensure that the policy is well implemented, nor is it sufficient to state that individual members are responsible for understanding the policy. Given the historical persistence of this problem, the Commissioner must take more active measures to ensure that all detachment commanders discharge their management responsibilities respecting this critical area of the policy.

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[3] Findings:

5. At the detachment, Mr. Nielsen remained uncommunicative and unable to walk although he made what appeared to be some rudimentary efforts to respond to instructions. I find as a fact that Mr. Nielsen was in a state of 'questionable consciousness' from the time Constable Bes attended at the New Life Mission at approximately 10:47 a.m. until he was placed in the cell at approximately 11:05 a.m. Accordingly, pursuant to the relevant RCMP policy, Mr. Nielsen should not have been placed in the cell.

7. To an officer or civilian guard properly trained to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion, Mr. Nielsen's inability to communicate, in conjunction with the obvious signs of acute alcohol intoxication, should have indicated the need to secure prompt medical attention for Mr. Nielsen.

8. To an officer or civilian guard properly trained to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion (the hypodermic needles in his possession, the 'tracks' and the fresh needle mark) in combination with the obvious indicia of acute alcohol intoxication should have indicated the need to secure prompt medical attention for Mr. Nielsen.

My Findings No. 18 and 19: The Commissioner agrees with these Findings, therefore no further comment is necessary.

My Finding No. 20:

> *20. On the basis of the information provided to me by the RCMP, I find that Depot does not adequately train Cadets to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion.*

I have considered the comments of the Commissioner and reiterate my Finding No. 20.

I have reviewed in detail the additional information referred to in the Commissioner's Notice. Although the additional information has been useful in assisting us with our ongoing investigation in this case, I am disappointed that it was only provided to us after the Commission received the Commissioner's Notice. I am particularly concerned given the numerous requests made to the RCMP during the Commission's investigation in this case. However, I am confident that this case was the exception and not the rule.

I have now had the opportunity to further assess the Cadet Training Program. I commend the RCMP for the efforts taken to increase available training materials that are useful in assisting the officers to perform arrests and to detect signs and symptoms of drug or alcohol abuse. There is nothing, however, in the additional materials that leads me to conclude that Cadets are adequately trained to recognize the signs and symptoms of acute alcohol poisoning alone or in combination with drug ingestion. A review of the materials indicates that the focus is on assessing and minimizing the risk to the officer, an important training objective, but that there is not sufficient regard given to the protection of the public. In addition, I remain concerned about the availability, or lack thereof, of current and up-to-date research materials to members in the field, particularly given the RCMP's own advanced research in this area.

As noted in the Interim Report, inadequate training on this issue may result in a policy dealing with medical assistance for detainees that is not properly understood or applied. The facilitator's notes (Module VI, Session 9) quoted by the Commissioner in his Notice, highlight the extent to which the policy is misunderstood. On two occasions, the facilitator is instructed to tell Cadets that if the person in custody is "unconscious," medical attention must be obtained. That instruction, while true, is not sufficient. Clearly, the facilitator's note does not prepare Cadets to respond appropriately to a detainee in Mr. Nielsen's condition. In fact, the relevant policy requires medical attention if the detainee is in a state of "questionable consciousness." I believe that additional instruction is necessary to ensure that facilitators properly understand this critical aspect of the relevant policy. In turn, this will ensure that accurate information is provided to Cadets.

My Finding No. 21:

> *21. Prior to May 21, 1997, the day Mr. Nielsen was found unconscious in his cell, I find civilian guards at the Kamloops City RCMP Detachment were not properly trained to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion, with the result that the RCMP policy dealing with medical assistance for detainees was not well understood or applied.*

I have considered the comments of the Commissioner and reiterate my Finding No. 21.

I have taken note of the efforts made by Mr. McKinley following the death of Mr. Nielsen to increase and improve the training of civilian guards. However, as established by the Commissioner's concurrence with Findings No. 5, 7 and 8,[4] the guards at Kamloops City RCMP Detachment did not properly understand, or implement, the relevant national policy. Despite the fact that guards are municipal employees, I believe that the RCMP has a responsibility to the public and to those in its care, to ensure that guards are properly trained. The guards did receive training relating to the policy on medical procedures and had some experience handling persons under the influence of alcohol, but there is no indication that they received adequate training to help them recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion.

The references to the number of liquor related arrests, in the Interim Report, were made for the sole purpose of highlighting the significance of the problem and the frequency with which the members of Kamloops City RCMP Detachment have to address these issues. I cannot comment on the incidents that required members or guards to summon medical help. I cannot, however, agree with the statement that "[t]he evidence further indicates that the guards, based on the knowledge that they had acquired, did not hesitate to request medical assistance." In fact, in the case of Mr. Nielsen, members and guards under their supervision failed to request medical assistance for a detainee of **questionable** consciousness. Medical assistance was obtained only after Mr. Nielsen was **unconscious**.

My Finding No. 22:

> *22. The Course Training Standard (CL8500) for a Guards Training Course is inadequate in the crucial area of assessing the need for medical assistance for detainees. As well, it would appear that the existence of this Course Training Standard is virtually unknown and, therefore, that Divisional use of this Standard, in the manner contemplated by the Commissioner's response to the Robinson/Farewell recommendations respecting civilian guards, was never implemented.*

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[4] *Ibid.*

I have considered the comments of the Commissioner and I reiterate my Finding No. 22. I remain of the view that the Course Training Standard CL8500 (CTS) is inadequate for the reasons stated in the Interim Report. However, I am encouraged by the statement that a new CTS is being designed and hope that improvements will include training in the manner contemplated in my Recommendation No. 1. I note that the improved CTS will be made available to detachment commanders, who will be instructed to ensure that the guards receive appropriate training. I would appreciate being apprised of the improvements to the CTS when they are implemented.

I note that, in the meantime, detachments will be made aware of the availability of the current CTS and of the requirement to use it. Given the fact that these matters touch on "a particularly difficult and important area of [RCMP] duties," I remain concerned that there is no requirement to ensure that a copy is distributed on a timely basis, to each detachment. This is a simple task and it should be done.

My Finding No. 23: The Commissioner agrees with this Finding, therefore no further comment is necessary.

My Recommendations No. 1, 2 and 3:

> *1. Provide training to all operational members, and Cadets, to assist them in recognizing the symptoms of acute alcohol poisoning alone or in combination with drug ingestion in order to better enable them to determine if persons in their custody need immediate medical assistance. Such training should ensure, among other things, that members can use and understand a straightforward assessment aid and check list similar to the Glasgow Coma Score and/or the Metropolitan Police Service [London, England] policy commonly known as the "4R's of Rousability".*
>
> *2. The officer in charge of every detachment should ensure that all civilian guards are given access to training of the type contemplated above.*
>
> *3. Post a straightforward assessment aid and check list similar to the Glasgow Coma Score and/or the Metropolitan Police Service policy commonly known as the "4Rs of Rousability" in a conspicuous location in the guardroom and/or the booking area of every detachment.*

I have considered the Commissioner's comments and reiterate my Recommendations.

I am encouraged to note that relevant information concerning the issue of combined use of drug and alcohol will be included in the Cadet Training Program. However, with respect to members and guards, I continue to be concerned that detachment commanders are not required to make them aware of the new materials available.

I also note the development of a "First Responders Course" by "E" Division. I trust that similar courses will be available to all the members of the RCMP. When they become available, I would appreciate receiving a copy of the materials prepared for the purposes of this course.

I am satisfied that the RCMP Chief Forensic Officer will develop a check-off list, to be used in determining whether or not a prisoner should be referred for medical attention. I trust that the check-off list will be posted in every guardroom and/or the booking area of every detachment, as recommended in the Interim Report. I would appreciate receiving a copy of the check-off list once it has been distributed.

My Recommendation No. 4: I have considered the comments of the Commissioner and reiterate my Recommendation No. 4.

My Recommendation No. 5:

> *5. Ensure that all members and civilian guards have a solid and continuing knowledge and understanding of the operational policy dealing with medical assistance for detainees.*

I have considered the comments of the Commissioner and reiterate my Recommendation. I agree with the Commissioner that members have the responsibility to ensure that they are up to date with the policy in place, but it is also the responsibility of the RCMP to ensure consistency in the implementation of the policy, and to provide follow-up training for members and guards.

My Recommendation No. 6: The Commissioner agrees with this Recommendation, therefore no further comment is necessary.

My Recommendation No. 7:

> *7. Ensure that information available to the RCMP, like recent advances in the understanding of the lethal consequences of an alcohol/cocaine mix, is effectively communicated to operational members on an organized and regular basis.*

I have noted the comments of the Commissioner and reiterate my Recommendation No. 7. Adding new materials to the Learning and Development Web site does not adequately address my concerns regarding the need for training and refresher training. The Commissioner must ensure that follow-up training is provided to all members of the RCMP.

My Recommendation No. 8:

> *9. Ensure that every detachment designates a non-commissioned officer who is specifically charged with ensuring that civilian guards responsible for RCMP detainees are capable of undertaking the care and custody of detainees in accordance with all relevant RCMP policy.*

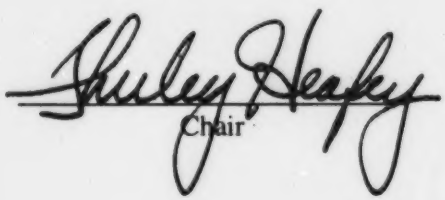
I have noted the comments of the Commissioner and reiterate my Recommendation. I appreciate that training provided to guards is to be delivered under the direction of the detachment commander or his delegate. However, historically, there has been failure by members and guards under their supervision to implement the relevant policy. Consequently, I have recommended that every detachment designate a non-commissioned officer who is specifically charged with ensuring that civilian guards are capable of undertaking the care and custody of detainees in accordance with all relevant RCMP policy.

III. CONCLUSION

I commend all members of the Kamloops City RCMP Detachment, and in particular Constable Bes, for their cooperative and forthright participation in a process that most certainly was not easy.

Finally, it is my hope that this issue will be effectively addressed by the RCMP in the months ahead.

Pursuant to subsection 45.46(3) of the *RCMP Act*, this is my final report to the Solicitor General and the Commissioner in relation to this complaint.



Chair

October 30, 2000

Shirley Heafey
Chair
RCMP Public Complaints Commission
P.O. Box 3423, Station "D"
Ottawa, Ontario
K1P 6L4

APPENDIX I

Royal Canadian Mounted Police | Gendarmerie royale du Canada

J.P.R. Murray
Commissioner | Le Commissaire

June 21, 2000

Protected "A"

Ms. Shirley Heafey
Chair
RCMP Public Complaints Commission
P.O. Box 3423
Station "D"
Ottawa, Ontario
K1P 6L4

Dear Ms. Heafey:

I acknowledge receipt of the interim report of February 17, 2000, file references 2000-PCC-981276, and materials relevant to the complaint of the Chair of the Royal Canadian Mounted Police (RCMP) Public Complaints Commission (PCC) concerning Mr. Kim Erik Nielsen.

On May 5, 2000, I examined the findings and recommendations. The following notice is provided pursuant to Section 45.46(2) of the RCMP Act.

After carefully reviewing the material and the PCC's findings, I agree with findings one to eleven, thirteen to sixteen, eighteen, nineteen and twenty-three. The following information will address the remainder of the findings and recommendations.

With respect to finding twelve, there is no medical evidence to support this finding. In fact, one would require some degree of medical expertise to comment on the possibility that if Mr. Nielsen had received medical attention when first detained, he may have survived the episode of acute alcohol intoxication combined with cocaine use. Consequently, comment with respect to this issue is best left to the medical profession.

Regarding finding seventeen, current national and divisional policy adequately addresses the requirement

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1200 Vanier Parkway
Ottawa, Ontario
K1A 0R2

1200, promenade Vanier
Ottawa (Ontario)
K1A 0R2

to provide medical attention to persons in custody. The detachment commanders are responsible for ensuring that their personnel abide by existing policy when the need for medical attention exists. If any particular member does not understand the policy, he or she should discuss the matter with his or her supervisor and, if confusion remains, the appropriate policy centre would be able to interpret the policy in question.

With finding twenty, it would appear that not all the information pertaining to the Cadet Training Program regarding the use of alcohol and drugs was provided to the PCC during the course of its investigation. For example, under the heading "Information Gathering", the Incident Management/Intervention Model indicates that one of the factors to be considered is whether or not drugs or alcohol is involved.

In Module X, Session 6 of the Cadet Training Program, a specialist in alcoholism presents a session on alcoholism, its symptoms and related behaviours. During this session, it is stated that "moreover, as police officers, you will be responsible for intoxicated persons in your custody and you should be aware of what alcoholism is and its impact on behaviour to ensure that your interactions with these individuals are professional." In addition, it is also stated that "in your role as a police officer, when interacting with inebriated people, never assume the individual is just drunk" and "if unconscious, make sure that the individual is attended to by a physician."

During this session, different kinds of drinkers, as well as available treatment and support programs, are discussed and cadets view a video and discuss the progression of alcoholism. In addition, cadets discuss what they should know about interacting with inebriated persons in their role as police officers.

The handouts used for Session 6 include the Controlled Drugs and Substances Act which is addressed in Module XI of the Program. In this module, cadets complete a questionnaire on the Act, and reference material provides a list of controlled substances, background information on the substances, and the short- and long-term effects of these substances. In Session 1, Module XI, a video entitled "Drug User Recognition", which demonstrates eye and body movement

and speech, is viewed. The viewing is followed by a discussion which includes the signs and symptoms caused by drugs and what a police officer should look for.

Cadets are informed of the RCMP's Learning and Development Web site and are required to use it for research purposes during training. A search for "drug abuse" on the RCMP's Learning and Development Web site identifies Web sites such as the National Institute on Drug Abuse and Cocaine Induced Psychosis by Dr. Cecil Wingo. "Alcohol abuse" identifies the Web site of Risk Assessment and Plan of Action and "alcohol poisoning" identifies the Web site of Persons in Custody Exercise and Care and Handling of Prisoners.

It should also be noted that, during the Learning and Development Branch's Employee Continuous Development Program Workshop that is provided primarily to supervisors, the Learning and Development Web site is discussed. In addition, the training coordinators located in the divisions will provide hard copy documentation of any information from this Web site to any member who does not have access to the Internet.

In Module VI, Session 9, a note to the facilitator states that:

> It is important that cadets realize the dangers involved with incarcerating severely intoxicated individuals in cells. We have had numerous individuals die in cells in the past few years. Therefore it is very important that if the person is unconscious he should be brought to hospital. The guard must make sure the prisoner is not unconscious or needing medical attention.

The Cadet Training Program, with respect to alcohol abuse and drug ingestion, is extensive. Cadets should, therefore, be able to recognize the symptoms of acute alcohol poisoning and should also be able to understand and apply policy dealing with medical assistance for detainees. At this time, the Program does not, however, train the cadets to recognize the symptoms of acute alcohol poisoning in combination with drug ingestion.

With respect to finding twenty-one, the documentation does not indicate that the guards at the Kamloops City

Detachment received specific training focused on recognizing the symptoms of acute alcohol poisoning alone or in combination with ingestion of drugs. However, the evidence does indicate that Mr. McKinley, Provost Supervisor, conducts a verbal test of a trainee's knowledge at the end of the initial eighty hour training period, and that he maintains a check list which covers areas of knowledge on the training manual including such items as RCMP policy relative to the job requirements. The trainee is required to present his or her knowledge about medical procedures. In addition, Mr. Haison, a civilian guard, stated that he was required to study numerous manuals and policies which covered unusual circumstances that may arise, including illnesses.

Mr. McKinley further stated that there were 1,521 Liquor Act arrests in 1997, resulting in 70 requests for ambulance assistance to the guard room due to medical requirements. Of these 70 requests, 49 persons were transported to the Royal Island Hospital for treatment. The remainder received treatment in the cells and remained there.

The evidence indicates that the guards at Kamloops City Detachment reviewed the policy on medical procedures, and were familiar with handling persons under the influence of alcohol, having dealt with 1,521 liquor related arrests in 1997. The evidence further indicates that the guards, based on the knowledge that they had acquired, did not hesitate to request medical assistance. They had done so on 70 occasions when they believed that it was necessary.

Regarding finding twenty-two, under the heading of Safeguarding Prisoners in Course Training Standard (CTS) CL8500 for the Guards Training Course, it is indicated that emphasis will be placed on a complete explanation of relevant Operational Manual Policy, and Division and Unit Supplements. Under the same heading, Emergency Procedures address the subject of ill prisoners, however, the CTS, as developed in January 1992, does not include training in the manner contemplated by the PCC. This issue will be further addressed under recommendation two.

With respect to the awareness of the CTS by detachment personnel, the CTS was forwarded to the Training Coordinators in the divisions, however, there appears to have been some difficulty in providing a copy of it to the detachments in need. I will, therefore, request that the Learning and Development Branch ensure that all

detachments where cells are located are made aware of theavailability of, and the requirement to use, the CTS.

Regarding recommendations one, two and three, the Cadet Training Program presently includes extensive training pertaining to the signs and symptoms of alcohol abuse and of drug abuse. It does not, however, include symptoms related to a combination of drug and alcohol abuse. I will, therefore, request that the Learning and Development Branch include relevant information concerning this issue in the Cadet Training Program.

Material is currently being gathered which will include information on acute alcohol poisoning, positional asphyxia, and excited delirium which is described as "being out of control" as a result of substance abuse. The material will include the Glasgow Coma Score, and will be made available to all detachment commanders who will be encouraged to share it with civilian guards as part of their training/orientation. I will request that the Community, Contract and Aboriginal Policing Services and the Learning and Development Branch ensure that information pertaining to the symptoms related to a combination of drug and alcohol abuse is included in the material that is to be provided to the detachment commanders.

In addition, a new CTS is being designed based on a functional job analysis for guards and matrons, to identify the specific knowledge, techniques and skills required to provide quality service to address the learning requirements identified. I will, therefore, request that the Community, Contract and Aboriginal Policing Services and the Learning and Development Branch ensure that the material being gathered is included in the new CTS, and that each detachment commander ensures that the guards and matrons receive appropriate training.

The Glasgow Coma Score and the "4R's of Rousability" have been provided to Mr. Leo Walter, the Chief Forensic Officer in Edmonton, Alberta, for review, and he has been asked to develop a check-off list to be used to determine whether or not a prisoner should be referred for medical treatment.

This document will be made available through the RCMP's Learning and Development Web site under the heading of First Aid. I have also requested that "E" Division include the "4R's of Rousability" in the development of the First Responders Course currently being designed.

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Behaviours under Care, Handling, Arrest and Release of Detainees specified in the assessment procedures for cadets and members in the Field Coaching Program will include: "Identifies and discriminates among symptoms of prisoners of alcohol and drug abuse and calls for medical assistance as required." In addition, a check list or assessment aid ill be made available in the learning material and detachment commanders will be requested to post it in their cell block areas.

With respect to recommendation four, depending on the circumstances of the arrest, this information may or may not be readily available to the arresting officer. However, through the "CAPRA" model, members are encouraged to ask as many questions as possible to determine for themselves or to allow qualified personnel to quickly determine the condition of the individual. However, it should not be expected that a police officer would or could do anything more than a preliminary diagnosis. The importance of obtaining this information, whenever possible, will be mentioned in the material being gathered.

In response to recommendation five, policy will be included in the Cadet Training Program and is readily available through the Learning and Development Branch Web site for reference when required. National policy is clear on this issue and policy awareness is part of the CTS for guards and matrons. It is incumbent upon all employees to remain current and to regularly review this policy.

Regarding recommendation six, in policy, on all postings in detachments and in all related training materials, the message "When in doubt, call for medical assistance!" will be included. The preference to "err on the side of caution" will be addressed in the learning material.

With respect to recommendation seven, updates of material resulting from the continued research of the Learning and Development Branch and of Health Services on alcohol and/or drug use, symptoms and responses will be made available on the Learning and Development Web site.

In response to recommendation eight, the CTS for the Guards Training Course states that "This is a one and a half day divisional course designed to be presented by a detachment commander or his delegate, wherever guards are employed

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or about to be employed by the Force". Direction has, therefore, been provided with respect to the designation of a member who is charged with ensuring that guards are capable of undertaking the care and custody of detainees in accordance with policy.

The issues raised in the Historical Context under the Public Complaints of Mr. Donald Robinson and Mrs. Beverley Farewell (2000-PCC-89168/89287) and Ms. Donna Wilson (2000-PCC-950295) have been addressed in Appendix A.

This is a very thorough analysis of a particularly difficult and important area of our duties. The care, handling and well-being of persons in custody are taken very seriously by the RCMP. We handle an incredibly high number of persons under the influence of alcohol, drugs or some combination thereof, and this is one of the most high risk aspects of our role. The analysis by the PCC will be very helpful in ensuring that our members and guard staff have the most up-to-date research available to help them ensure that persons in custody receive appropriate medical treatment when certain symptoms are evident. I find the recommendations to be reasonable and commit to implementation in a timely way. Implementation of these recommendations will assist in reducing the level of risk of death of persons in custody. I thank the PCC for a very thorough and helpful report. I will ensure our ultimate policy changes are reflected in the High Risk Category of our quality assurance program.

I thank you for your advice, and I look forward to receiving your final report.

Sincerely,

J.P.R. Murray

Enclosure

The Commission stated, in the Public Complaint of Ms. Donna Wilson, that they found it necessary to repeat certain recommendations from the Robinson/Farewell Report. The recommendations from the Robinson/Farewell Report (5.2, .3, .4, .6, .7 and .8) that were repeated were included under recommendation 11 in the Wilson report and are stated as follows:

5.2 *The RCMP should ensure that all of its officers carrying out duties within Yukon recognize the responsibilities imposed on them when taking a person into custody under the authority of The Yukon Liquor Act. In particular, those officers must appreciate that they are subject to a statutory obligation to observe whether or not the person taken into custody is in need of remedial treatment by reason of the use of alcohol and, if so, that there is an obligation to take that person to a physician. With the increasing use of a variety of chemical substances in the general population, the significance of these responsibilities to the RCMP officer should be obvious. A complete and accurate record should be kept of the manner in which these responsibilities are fulfilled.*

Of equal significance, the officer taking such person into custody should, at the earliest opportunity, determine whether or not there is an adult person who is willing and capable of taking charge of such person. If so, the adult person should be encouraged to do so rather than proceeding to place the intoxicated person in a cell. A record should be made of the efforts undertaken to find an adult willing and capable of accepting the responsibility for the care and custody of the intoxicated person.

5.3 *When a person is taken into custody, whether by reason of intoxication or otherwise the arresting officer must observe and record on the Prisoner Record the physical condition of the prisoner. The record itself is valuable, but even more valuable is the requirement on the part of the arresting officer to make the observation. Without this step being taken, the discharge of the duty of care becomes questionable.*

5.4 *Once a prisoner has been placed in a cell, frequent and accurate observations should be made of the activities and condition of the prisoner and a full record of such observations made by entry in the cell log or, if necessary, by supplemental report. If at any time it becomes necessary to remove a prisoner from the cell, such activity should only be carried out by two officers, an officer and one guard or by two guards. The time of removal should be entered in the cell log and a separate report made of the reason for such removal and any activity or occurrence which takes place while the prisoner is outside the cell. This report should be signed by both persons involved in the process. A notation should be made in the cell log of the time of the return of the prisoner to the cell.*

5. 6 *The officer in charge of each Detachment should ensure that each officer and civilian guard reads and understands the RCMP operational manual and any Detachment supplement which pertains to the care and handling*

of persons in custody. Regular instruction should be instituted to ensure that this requirement is met. In the course of providing this instruction the officer in charge of the Detachment should obtain the assistance of qualified medical personnel who can instruct the officers and the civilian guards in the early recognition of signs and symptoms which, when exhibited by prisoners, indicate the need for medical assessment or assistance. Each officer or civilian guard should be aware of the consequences of a combination of alcohol or substance abuse with or without physical injury and the symptoms to be looked for. Periodically the officers and guards should be tested for their knowledge of and practical response to this aspect of custodial care.

5. 7 Each detachment should maintain a roster of the names and phone numbers of medical personnel available to serve the needs of the Detachment on a 24 hour basis.

5.8 When the cells are occupied by more than one prisoner, the civilian guard should not be left on duty alone. In such circumstances, a second guard or an RCMP officer should remain in attendance at the detachment to assist in the event of any emergency. "

The Commissioner's notice dated December 17, 1990 stated the following concerning recommendation 5.2 of the Robinson/Farewell Report.

The Force policy is clear and appropriate. Members are required to comply with statutory obligations, including the Offences Act of British Columbia for those members stationed in that province. In regards to section 81 (1)(b) of that Act, there is no requirement for the police officer to seek out an adult who appears to be capable of taking charge of such a person. It is understandable that no attempt was made by the arresting officer. I will, however, instruct the Director of Enforcement to examine our policy and determine whether it is appropriate.

The Officer in Charge, General Enforcement Branch replied on November 22, 1991, stating the following:

> With respect to Recommendation #2, concerning Section 81(1)(b) of the B.C. Offences Act, this issue was examined by the former OIC Contract Policing Branch who felt it is usually in the best interests of all concerned to keep an intoxicated person in custody until sober. At times it may be appropriate to release a person, especially a young person to a responsible adult if the person will not use violence and the responsible person is willing to take care of the individual. I suspect this does happen on occasion but there is no need to include it in policy.

The Commissioner's notice dated December 17, 1990, also stated the following concerning recommendations 5.3, .4, .6, .7, .8 and .9 of the Robinson/Farewell complaint:

> In light of the recommendations, the Force policy has been examined and I am satisfied that the policy is appropriate with respect to custodial care of prisoners. I will, however, instruct the Director of Training to examine recommendation 6 and determine whether members and civilian guards should receive additional instruction in recognizing the signs and symptoms which indicate the need for medical assessments of or assistance to prisoners.

The Acting Officer in Charge, Training and Development Branch replied on March 11, 1991, stating the following:

> An examination of the training requirements of our members and civilian guards relative to recognizing the signs and symptoms of prisoners requiring medical assessments has been conducted.
>
> The Training Academy were asked for input and they concluded that no additional training is needed during Basic Recruit Training as the whole issue of care and handling of prisoners is covered extensively. As well, First Aid Training covers signs, symptoms and appropriate first aid procedures for such injuries and conditions of concern in this matter.
>
> Further, the care and handling of prisoners is covered in Recruit Field Training during the six months following Basic Recruit Training. The First Aid recertification requirements of the Force requires the matter to be reinforced on a regular basis, every 3 years.
>
> Research Section of Training and Development Branch are presently evaluating a Course Training Standard (CTS) for Guards and Matrons. The CTS includes care and handling of prisoners and First Aid Training to allow them to assist regular members in the initial care of sick or injured prisoners. Once approved and training of civilian guards is implemented, the necessary action will have been taken from a Training Directorate perspective to meet the Commissioner's intent. Approval of the Guards and Matrons Training CTS is anticipated by April 15, 1991.

Subsequent correspondence from Learning and Development Branch, dated May 19, 1998, advised that CTS CL8500 for Guards and Matrons, had been approved. Learning and Development Branch advised that the course is a divisional course which is delivered by the divisions as required.

In addition to the above, Learning and Development Branch responded to the recommendations in the Wilson Report on April 16, 1997, stating the following:

> Recommendation 2
>
> Current Policy in III.3.E.3 of the Operational Manual is very clear as to when medical treatment is to be provided to a person in the custody of a police officer. The Cadet Training Program, in Module VI, deals with the Care and Handling of Prisoners. As part of this Module, the cadets are required to research material and are then required to answer a questionnaire regarding persons in custody. The questionnaire addresses the issue of when medical attention for a prisoner should be sought. Their research requires them to refer to the above policy. In module XI, of the Cadet Training Program, the Narcotic Control Act and the Food and Drugs Act are presented. Cadets are introduced to drugs most commonly abused. Signs and symptoms displayed by users are discussed during Session I on the module. A video titled "Drug User Recognition", is shown to point out the different effects, signs and symptoms that a police officer should be aware of when investigating occurrences where drugs may be involved. The policy in II.19.H.4.a. of the Administrative Manual clearly requires a member in operational duties to renew their CPR certification annually and First Aid Certification every three years. Module 2, a mandatory component of the Saint John's Ambulance Course deals with Shock, Unconsciousness and Fainting. Signs and symptoms that are the result of a seizure are discussed in this module.
>
> I suggest that creating additional policy would not help to prevent future serious occurrences. The RCMP is currently in the process of developing the Employee Continuous Development

Program (ECDP) to address competency gaps and to provide current training/learning on-site to employees as required. A list of the signs and symptoms will be added to the data base that will be made available on the Internet as it applies to First Aid.

Recommendation 3

Chapter II.19.H.4.a of the Administration Manual makes it mandatory for members of the RCMP who are in operational duties to renew their CPR certification annually, and First Aid Certification every three years. The ECDP will allow members to have access to new material as it becomes available. This system will also be accessible to other police agencies.

Recommendation 4

Working in partnership and in consultation with the community will enable members of the RCMP and their partners to provide better service to the people they serve. Cadets who leave the Training Academy are required to do a community profile. This profile outlines who in the community can assist the police in various circumstances. Doctors and nurses, for example, are recognized as partners. The profile will encourage members to arrange sessions with each group to recognize what each can do to assist in their delivery of service.

Learning and Development Branch, subsequent to the above noted correspondence, advised that they have added considerable information on the signs and symptoms of drug abuse and overdose and the ways in which drugs interact with alcohol to the RCMP Learning Network (www.rcmp-learning.org). This information consists of links to already existing web sites such as Health Canada, Drug Abuse Resistance Education, Addictions Life Page and The National Clearinghouse for Alcohol and Drug Information. At the present time, RCMP produced material is being obtained from the Toxicology Section in the Forensic Laboratory at Vancouver, British Columbia.

Contract Policing Branch also addressed the recommendations of the Wilson Report on October 22, 1998. The Director Community, Contract and Aboriginal Policing Services, in correspondence dated September 18, 1998, that was addressed to all Commanding Officers stated the following:

The death of Mr. Robert Keddy in Whitehorse Detachment cells in 1995 was the subject of a public complaint by Ms. Donna Wilson. As a result of this complaint, the RCMP Public Complaints Commission produced an Interim Report making recommendations to Commissioner Murray. Based on the response by the Commissioner to the findings and recommendations in this report, Contract Policing Branch has reviewed national policy related to the care and handling of prisoners.

Please ensure that members in dealing with prisoners are made familiar with present policy and that all green sheets are in line and not in contradiction to the present national policy and that detachment/unit supplements are updated accordingly. Additionally, we recommend that a list of available medical personnel is appropriately placed in the cell area of all detachments.

Please find enclosed, a review and response to the Commissioner's comments by this Directorate.

Recommendation 1

National policy on the care, handling and custody of prisoners, which is the responsibility of this Directorate, is clear. The weaknesses, identified by the Public Complaints Commission,

were in the delivery of this policy to members and in the definition of acute alcohol poisoning, drug overdose, etc. Policy is available in all detachments in hard copy and in electronic format for those detachments that have access to the RCMP Office Support System (ROSS). The inability to locate policy within a detachment is not an issue that can be addressed by this Directorate. Divisional/detachment policy is the responsibility of the appropriate detachment/divisions, the requirement from national policy centre is that Divisions make efforts to align their policy with national policy, taking into account specific needs and requirement of their jurisdictions. Medical Treatment, according to O.M.III. 3.E. 3 ., is to be sought "If there is any indication that a person in your custody is ill, suspected of acute alcohol poisoning or drug overdose, injured or not fully conscious, even if the person denies same,...". The words "any indication" are broad enough to allow any uncertainty to be an error on the side of caution. Recognition of symptoms of these conditions is being addressed by Learning and Development in Recommendation 2.

Action taken: Policy reviewed, no revision required.

Recommendation 4

Refer to O.M III 3 Prisoners and Mentally Disturbed Persons, where it clearly states that.."If there is any indication that a person in your custody is ill...ensure that he/she:

1. is examined by a medical practitioner;
2. receives immediate medical treatment; and
3. is not placed in a cell unless a medical examination finds him/her fit to be incarcerated".

National policy directs the custodian to seek the assistance of trained professionals. Unless these professionals are employees of the RCMP we have no way of "ensuring" their availability.

Action taken: This Directorate will recommend that all Commanding Officers require a list of available medical personnel be appropriately placed in the cell area of all detachments.

Recommendation 6

National policy states several instances whereby a prisoner is to be incarcerated separately. As the Commissioner states, it would be unrealistic and not enforceable to attempt to detain all intoxicated persons separately. We leave it to a member's discretion and common sense to separate detainees, particularly if they pose a threat to others, when necessary and reasonably possible.

Action taken: Policy reviewed, no revision required.

Recommendation 7

Acquisition of surveillance equipment, such as CCTV's, is a Divisional responsibility.

Action taken: Policy reviewed, no revision required.

Recommendation 10

Once this sort of policy information system is in place, the need for a pocket-size operational manual is eliminated.

Action taken: National policy will be reviewed to ensure that ambiguities are removed and that direction is clear and concise. This Directorate will recommend, in light of this decision, that

all Commanding Officers ensure their policy is aligned with national policy and that detachment/unit supplements are updated accordingly.

The Commission's recommendation number 12 in the Wilson Interim Report suggested that the RCMP senior management review and monitor the extent to which the RCMP has implemented their recommendations. The Commissioner's notice dated November 21, 1997 stated "I agree that the RCMP must have a method of monitoring and reporting the implementation of the RCMP Public Complaints Commission's recommendations." In the Force's Accountability Report of May 5, 1999, the Commission was advised that, as per an agreement with the Solicitor General Secretariat on May 13, 1996, all public complaints containing general policy issue recommendations are included in the Annual Accountability Report to the Solicitor General. All other public complaints are closely monitored to ensure that the recommendations contained in the reports of the RCMP Public Complaints Commission, to which the Commissioner had agreed, are complied with.

It would appear that there has been some difficulty in providing a copy of the CTS for the Guard Training Program, however, the appropriate policy centre has now been requested to ensure that a copy of the CTS is provided to the detachments in need. This should resolve the difficulty in this regard. As indicated above, concerning other public complaint files, these files are not concluded until confirmation has been received indicating that the Commissioner's direction has been complied with.

The Commission also stated in their summary of the Wilson complaint that they found it necessary, in their Final Report, to reiterate the need for refresher training in the detection of signs of alcohol and drug abuse because the Commissioner had failed to address it in his Notice.

In response to recommendations 2 and 3 of the Commission's Interim Report dealing with training and refresher training, the Commissioner's notice of November 21, 1997 stated "Although Cadet training appears to cover most if not all the areas of concern raised by the Commission, there appears to be a lack of in-service refresher training in this area. This topic should be reviewed at both national and divisional levels and appropriate amendments should be put in place to ensure that members are properly informed and kept up-to-date on this critical subject." The result is the learning material that is noted above. The learning material will be provided to all detachment commanders. It will also be used to update the current CTS for the Guard Training Program.

APPENDIX II

CANADA

RCMP PUBLIC COMPLAINTS COMMISSION

CHAIR'S INTERIM REPORT

PURSUANT TO SUBSECTION 45.43(3)

FOLLOWING A PUBLIC INTEREST INVESTIGATION

PURSUANT TO SUBSECTION 45.43(1)

INTO THE CHAIR'S COMPLAINT RESPECTING MR. KIM ERIK NIELSEN

February 17, 2000

File No.: 2000-PCC-981276

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CHAIR'S INTERIM REPORT
FOLLOWING A PUBLIC INTEREST INVESTIGATION

Introduction

On May 31, 1997, at approximately 16:38 hours, Kim Erik Nielsen died at the Royal Inland Hospital in Kamloops, British Columbia 10 days after being detained and held in RCMP custody. The verdict following a Coroner's Inquest held that "...the medical cause of [Mr. Nielsen's] death was accidental, brain damage, cardiac arrest, alcohol overdose as a result of substance overdose."

When the circumstances surrounding Mr. Nielsen's death came to my attention, I was concerned by certain historical parallels. Specifically:

- In 1988, Donald J. Robinson was assaulted while in RCMP custody. Despite suffering severe injuries that required hospitalization, he was not given access to medical treatment and was compelled to seek such treatment on his own, following his release. The then Chair of this Commission exercised his discretion to institute a public hearing to inquire into several public complaints about this incident (the Robinson/Farewell hearing). As required, a Panel of this Commission conducting that hearing made findings and recommendations which were conveyed to the Commissioner of the RCMP.

- In 1995, Robert Keddie died while in RCMP custody. Despite definite indicators that he was ill, suffering from acute alcohol poisoning and was not fully conscious, he was not given access to medical treatment. The then Chair of this Commission exercised his discretion to institute a public hearing to inquire into a public complaint about this incident (the Wilson hearing). As required, a Panel of this Commission conducting that hearing, of which I was a member, made findings and recommendations which were conveyed to the Commissioner of the RCMP.

It was in this historical context that I initiated a complaint about the treatment of Mr. Nielsen pursuant to subsection 45.37(1) of the *RCMP Act* and decided, in accordance with subsection 45.43(1), to commence a public interest investigation into the conduct of members, and other persons, responsible for the well-being of Mr. Nielsen while in RCMP custody.

The Magnitude of the RCMP Responsibility

The care and handling of persons in its custody is an important and recurring RCMP responsibility. That responsibility is frequently assumed in relation to 'at-risk' detainees who are often suffering from acute alcohol intoxication and/or drug overdose and include people suffering from mental or physical illness or injury. Special care in dealing with

this population is essential to prevent unnecessary deaths in police custody. Such special care is incumbent on the RCMP if it is to satisfy its legal duty of care because, as the British Columbia Court of Appeal noted in a decision released in 1999, "[g]enerally speaking, when a person is taken into custody, the only means or avenue through which he or she may obtain medical attention for an injury [or illness] is through the police."[1]

In the course of this investigation, I reviewed certain "Guardroom Statistics" relating to the Kamloops City RCMP Detachment. I do not believe a detailed examination of these statistics is necessary for the purposes of this report **but it is worth noting that intoxication was a factor in approximately one third of the detentions at the Detachment**. It is also worth noting that, in 1997, ambulances were summoned to the guardroom 70 times and, on 49 occasions, it was necessary to transport the detainee to hospital. In 1998, ambulances were summoned 80 times and, on 61 occasions, it was necessary to transport the detainee to hospital.

Based on the foregoing, it would appear that, at the Kamloops Detachment, members of the RCMP, and civilians under their supervision, are called upon to make a critical assessment of the need for immediate medical attention approximately once a week. This is not a small part of a member's job.

This information confirmed my understanding of the magnitude of the responsibility assumed by the RCMP in relation to persons held in their custody and it was with that understanding that I initiated this complaint and undertook this investigation.

The Complaint

On September 21, 1998, I initiated a complaint that

> "[a]lleged omissions or failures by Constable Peter John Bes as well as of any other members or other persons appointed or employed under the authority of the *RCMP Act* in the care and handling of Mr. Kim Nielsen during the specific time period between his detention by Constable Bes and the time he was put in a "drunk tank" at the Kamloops RCMP Detachment on May 21, 1997."

The then Solicitor General of Canada, the Honourable Andy Scott, Commissioner of the RCMP, J.P.R. Murray, Assistant Commissioner, M.J. Johnston, O.I.C. "E" Division and Constable Peter Bes were notified of the complaint. Shortly after this notice was given, the Commission commenced its public interest investigation.

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[1] *Fortey (Guardian ad litem of)* v. *Canada (A.G.)*, [1999] 10 W.W.R. 600 (C.A.)

The Investigation

A Commission Investigator interviewed the following people in the course of the investigation:

- Mr. Lyle Peel - Counselor, New Life Mission, Kamloops, B.C.
- Constable Peter Bes – The Member who detained Mr. Nielsen pursuant to the *Liquor Control and Licensing Act* of B.C.
- Mr. Steve Haison - Civilian Jail Guard, Kamloops City RCMP Detachment, a Kamloops municipal employee.
- Staff Sergeant Wayne Fredin - Senior NCO on duty, Kamloops City RCMP Detachment.
- Staff Sergeant Bob Johnstone - Watch Commander, Kamloops City RCMP Detachment.
- Mr. Dennis McKinley - Provost Supervisor, Kamloops City RCMP Detachment, a Kamloops municipal employee.
- Mr. Robert J. Graham – Coroner, Coroner's Court of British Columbia.
- Ms. Bonnie Plugoway - Secretary, Phoenix Center, Kamloops, B.C.
- Mr. Leo Walter – Chief of the Toxicology Section, RCMP Lab., Edmonton and Acting Chief Scientist for all RCMP Toxicology Labs in Canada.
- Mr. Wayne K. Jeffery, B.Sc., M.Sc. - Civilian member of the RCMP, Head, Toxicology, RCMP Forensic Laboratory, Vancouver, B.C.
- Sergeant David N. Abel – RCMP Cadet Training Program, Support Officer.

Each of the above-mentioned individuals co-operated fully with the Commission Investigator. I want to thank them for the contribution they have made to this investigation and this Report. I particularly want to thank Constable Bes for his co-operation. I realize that his acts, and judgment calls, in the course of these events have been the subject of repeated, intense scrutiny and that would be difficult for anyone, in any situation. It is clear, however, that he rose above his personal discomfort to provide full and accurate information to this Commission.

The Commission Investigator was also given generous access to a number of important documents that shed light on the events in issue. Specifically, I have reviewed, and considered:

- The Prisoner Report;
- A video showing Mr. Nielsen's booking and detention;
- All relevant National, Divisional and Detachment policy;
- 1997 and 1998 Guardroom Stats - Kamloops City Detachment;
- A British Columbia Coroners Service Toxicology Report;
- A selection of scientific literature compiled by Mr. Leo Walter;
- The transcript of the Coroner's Inquest into the death of Mr. Nielsen, the "Verdict at Coroner's Inquest," the "Presiding Coroner's Comments" and all exhibits entered in the course of the inquest; and,
- The Facilitator Guide for Module VI of the Cadet Training Program and Instructor's notes relating thereto.

In addition to all of the foregoing, I have reviewed the Commission's Final Reports on the Robinson/Farewell hearing and the Wilson hearing as well as other materials in the public domain that bear on the subject of the care and treatment of people in RCMP custody who are ill or injured.

Findings of the Investigation

Before reciting in detail the findings I have made following my assessment of the relevant evidence, I want to make it clear that I am restricting my focus to the time period commencing when Constable Bes arrived at the New Life Mission and ending when Mr. Nielsen was placed in the "drunk tank" at the Kamloops City RCMP Detachment. The inquest conducted by presiding Coroner Robert J. Graham exhaustively reviewed the events after Mr. Nielsen was placed in the cell. In addition, in initiating this complaint, I was primarily interested in reviewing the decision to place Mr. Nielsen in the "drunk tank" instead of arranging immediate medical treatment. Accordingly, any other facts mentioned are included only to provide context.

I find as follows:

1. Sometime on the morning of May 21, 1997, an unknown male driver of a van dropped Mr. Nielsen off at the New Life Mission in Kamloops, B.C.

2. Mr. Lyle Peel was busy attending to his duties at the Mission when Mr. Nielsen arrived. Some time later, he became aware of Mr. Nielsen sitting on a bench on the deck of the Mission.

3. Mr. Peel described Mr. Nielsen's condition as follows:

> "...[H]e couldn't even hardly sit by himself, let alone walk."
>
> "...[H]e wasn't responding at all. He was just sitting there like a zombie, his eyes were open, he wasn't sleeping but he couldn't talk, he couldn't do anything. He was conscious."
>
> "I hadn't seen a guy look quite like he did when he was sitting up there – it was very strange."
>
> "I'd never seen him like that. Not that state."
>
> "...[I]t kind of bothered me [that I didn't get a chance to talk to the guy who dropped Kim off at the Mission] because Kim was in the worst shape that I'd seen him in. I'd never seen him in that bad of shape before...."

4. Mr. Peel was fairly well acquainted with Mr. Nielsen - in fact, he had been the best man at Mr. Nielsen's wedding some months earlier - and had often seen him in bad condition but had "...never seen him that bad."

5. Mr. Peel attempted to arrange Mr. Nielsen's placement with the Phoenix Center, a rehabilitation facility, but was unsuccessful. Even while making the attempt, he did not expect to be successful because of his understanding of the admission policies of the Phoenix Center (i.e. a client had to be sober for at least one day prior to admission).

6. Mr. Peel knew Mr. Nielsen well enough to later describe Mr. Nielsen as living an "addicted lifestyle." Mr. Peel believes that Mr. Nielsen had suffered a brain injury some years earlier which may have contributed to Mr. Nielsen's reported tendency to "black out a lot." This belief was not communicated to Constable Bes when he took Mr. Nielsen into custody.

7. Mr. Peel knew Mr. Nielsen to be involved in the use of drugs but did not know which one(s) he used.

8. To the best of Mr. Peel's recollection, there was a very strong smell of mouthwash emanating from Mr. Nielsen and "...that's definitely part of what he was on anyway." This came as something of a surprise to Mr. Peel because, in his estimation, he did not see Mr. Nielsen "as being at that point yet" (i.e. satisfying his addiction in this manner).

9. Mr. Peel telephoned the RCMP detachment about Mr. Nielsen and Constable Bes responded quickly. Constable Bes indicated that he received the call at 10:40 hours and arrived at the New Life Mission at 10:47 hours.

10. Constable Bes recalls Mr. Nielsen's condition on his arrival at the Mission as follows:

> "The gentleman we were referring to, Mr. Nielsen, was sitting up on a bench surrounded by a couple of other people. His head was up, his eyes were open, he was looking around. I went over and spoke to him - he just looked at me - he didn't answer."

11. Constable Bes also noticed the very distinctive odour of Scope or Listerine mouthwash on Mr. Nielsen's breath.

12. It is clear that Mr. Nielsen was incapable of walking from the deck of the Mission to the police vehicle unaided. Constable Bes offers the following recollection:

> "So myself and Mr. Peel each took an arm and lifted him up, he took two or three steps on his own and then he stopped walking and we carried him, one on each arm, carried him down the stairs to the back of the police car, leaned him against the police car, didn't hold him up at this point, he stood on his own, just sort of holding onto his arms while we unlocked the door. Once the door was unlocked, I had him backwards and placed him in the car. He displayed a little bit of help, he slid across the seat and laid down on the back seat. I shut the door, thanked Mr. Peel for his help and drove back to the police office which is only about six to eight blocks away."

13. Mr. Peel has no clear recollection as to how Mr. Nielsen was placed in the police car. He knew Mr. Nielsen could not have done it unaided and believes that Constable Bes placed him in the vehicle. He did note, however, that Constable Bes "...was really good, really gentle with him, never really bumped him or wasn't abusive at all with him. Just helped him into the car and that was basically it." I place particular weight on Mr. Peel's observations about Constable Bes' treatment of Mr. Nielsen because he had had previous occasion to involve police in the removal of intoxicated persons from the Mission and states that he always carefully observed the demeanour of the attending officer to ensure that his clients were properly treated.

14. Constable Bes recalls talking to Mr. Peel about Mr. Nielsen before placing him in the police car. Constable Bes was apparently advised by Mr. Peel that he knew Mr. Nielsen. Constable Bes was made aware of Mr. Peel's efforts to have Mr. Nielsen placed in the Phoenix Center. Mr. Peel was specifically asked if he had advised Constable Bes about Mr. Nielsen's history of head injury and blackouts. Mr. Peel believes that he did not impart that information to Constable Bes, or his impression that Mr. Nielsen was in the worst state that he had ever seen him in, recalling only that he was very busy at that time and spent "minimal" time with Constable Bes.

15. Mr. Peel considered it a "toss up" between an ambulance and the police but, ultimately, he thought that "...if he [Mr. Nielsen] just had a place to sleep for a bit he would be all right again."

16. The two to three minute trip from the Mission to the detachment appears to have been uneventful. Mr. Nielsen remained lying in the back seat throughout.

17. On arrival at the detachment at approximately 11:00 a.m., the police car entered a secure garage bay. According to the recollection of Constable Bes, Mr. Haison, the civilian guard, assisted Mr. Nielsen to slide out of the back seat of the police car. Mr. Nielsen "got partially out and just sat down on the floor." He was then assisted into a wheeled chair that is kept in the garage bay for the express purpose of transporting ill or intoxicated persons and moved to the booking area. He remained seated on that chair throughout the booking process. That chair, a photograph of which I have seen, has been described as a "secretarial-type chair" on wheels and without arms. I note that Mr. Haison confirms that he was present for Mr. Nielsen's move from the police car to the booking area but he has no specific recollection as to who assisted Mr. Nielsen.

18. During the booking-in process, which took approximately 5 minutes, Mr. Haison describes Mr. Nielsen's condition as follows:

> "Well his eyes were open. I think Constable Bes communicated with him – there wasn't too much of a response but I do believe there was some response be it grunts or whatever in answer to some questions....I really can't recall that, but there was - Constable Bes would ask him some information – I see that the prisoner report is fully filled out – so he must have got some conversation with him."

19. Constable Bes does not confirm that he had any conversation with Mr. Nielsen. Constable Bes noted the following:

> "We wheeled the chair into the guard room where we basically let him sit. The chair's got no arms and he sat there on his own, didn't have to be held, his eyes were open the whole time, he was conscious, looking around – when he was asked to do things, he did them."

20. Provost Supervisor Mr. Dennis McKinley was in the male guard office while Mr. Nielsen was being searched and, though he was not directly involved, he formed certain impressions. Specifically, Mr. McKinley believed that Mr. Nielsen was under the influence of alcohol but was not too far gone and was not one of the worst cases he had seen in the cells. When asked to take off his jacket, he made no attempt to do so but did raise his arms. Throughout the booking-in process, he was sitting up, his head was up straight and he was sitting in the chair unsupported. In summary, he appeared to Mr. McKinley to have some control.

21. In addition to the impressions of Constable Bes and Messrs. Haison and McKinley, there is video footage of Mr. Nielsen during the booking-in process. The video surveillance system then in use – it has since been improved - produced footage that could best be described as being of marginal quality and was of little assistance in depicting the condition of Mr. Nielsen when he was booked into the cells. The footage shows Mr. Nielsen seated on the chair described above. He can be seen raising his arms.

22. After being placed in the cell at approximately 11:05 a.m., Mr. Nielsen was searched in accordance with relevant policy. Both Constable Bes and Mr. Haison appear to indicate that they personally performed the search but, in any event, they agree that they found two used needles among Mr. Nielsen's effects. Mr. Haison believes that the needles were found in Mr. Nielsen's jacket. The remainder of his personal effects were unremarkable: two combs, sunglasses, personal papers, mirror, lighter, tobacco and an earring.

23. Constable Bes observed that Mr. Nielsen's "...right arm had track marks, I don't know how many and one relative fresh needle mark." Constable Bes later indicated that "[a] track mark or needle mark could be there anywhere from one half hour old to twenty four hours old...I've no idea when he had it." Mr. Haison did not notice the needle marks.

24. Mr. Haison noted that the Prisoner Report contains a behavioural coding system (VISEN Plus) to ensure that important information about any prisoner is readily available. Mr. Haison told the Commission Investigator that, in his view, the "Drugs" indicator should have been utilized because of the needles found on Mr. Nielsen's person and the recent needle mark. Commenting on this failure to record the evidence of drug use, Mr Haison said: "...it wouldn't have made any

difference anyway because he was just in for straight intoxication. That's what he was arrested for at the time." In fact, according to a "Joint Protocol" dealing with the use of VISEN Plus, the "Drugs" indicator is only to be used when the prisoner is required to take some form of prescription medication.

25. The Prisoner Report, which was prepared, for the most part, by Constable Bes, notes that Mr. Nielsen "cannot stand or walk or talk."

26. Mr. Haison decided to remove Mr. Nielsen's pants in order to complete his search for personal effects after the needles were found. Accordingly, after being booked in, Mr. Nielsen was wheeled into the cell on the chair, lifted out of the chair and placed on the floor. His pants were then removed in order to complete the search.

27. As can be seen from the video footage referred to above, and as Mr. Haison explained, Mr. Nielsen was arranged in the "recovery position" on the floor. The recovery position is designed to ensure that the subject's head and torso are clearly visible to the guards and to ensure that he does not asphyxiate if he vomits.

28. Following Mr. Nielsen's placement in the "drunk tank" at approximately 11:05 a.m., Mr. Haison kept a close watch on him by checking him visually at regular intervals. In accordance with the relevant policy, Mr. Haison stated that he checked Mr. Nielsen every 15 minutes but, in addition, he checked on him as he passed the cell attending to his other duties. At approximately 3:07 p.m., Mr. Haison looked in the window of the cell and could not detect Mr. Nielsen's breathing. Mr. Haison entered the cell and confirmed that Mr. Nielsen did not appear to be breathing. He sounded the alarm and, as a result, emergency medical crews were summoned and Constable Vecchio, with the assistance of others, immediately commenced cardiopulmonary resuscitation efforts. An ambulance crew arrived at approximately 3:20 p.m. and took over the resuscitation attempt. At approximately 3:50 p.m., after being stabilized by the paramedics, Mr. Nielsen was transported to Royal Inland Hospital.

29. Dr. Karpiak, an emergency room physician at the Royal Inland Hospital, testified at the inquest that Mr. Nielsen had arrived at the hospital after suffering a cardiopulmonary arrest "which means that there had ceased to be spontaneous breathing and no cardiac activity." He further testified that four minutes after cardiac or pulmonary arrest, irreversible brain damage occurs.

30. For ten days after his admission to hospital, Mr. Nielsen, who was described as "deeply comatose," was kept alive by means of assisted ventilation and other supportive measures. On May 31, 1997, on the instructions of his family, all life support systems were disengaged and Mr. Nielsen died.

31. A blood sample taken from Mr. Nielsen at the hospital at 5:11 p.m. the day he was detained was analyzed and the results set out in a Toxicology Report prepared by the B.C. Coroners Service. Ethyl alcohol was present to the extent of 0.36 milligrams per one hundred millilitres of blood (it is illegal to operate a motor vehicle in this country with a reading in excess of 0.08). Neither morphine nor cocaine was detected in the sample but a metabolite of the latter, benzoylecgonine, was present to the extent of 0.27 mg/l. A metabolite is a substance produced as the original substance ingested, in this case cocaine, is broken down by the body.

32. Constable Vecchio, a qualified RCMP breathalyzer technician, testifying at the inquest into Mr. Nielsen's death, calculated that, at the time of his arrest, approximately 6 hours before the blood sample was taken, Mr. Nielsen's blood alcohol reading would have been in the range of 0.45. He further testified that, when administering a breathalyzer test, if the sample shows a blood alcohol reading in the range of 0.35 to 0.40, he immediately stops the test and has the test subject transported to hospital.

33. The presence of the benzoylecgonine makes it clear that Mr. Nielsen had ingested cocaine sometime in the hours immediately preceding his detention. Mr. Walter, Acting Chief Scientist for all RCMP Toxicology Labs, advised that there were too many unknown variables to reasonably estimate the cocaine dosage consumed or the time of consumption.

34. While giving evidence at the inquest, Constable Bes discussed his understanding of the "questionable consciousness" section of the Divisional policy on medical treatment (see s. 5(b) in Appendix "A"). In short, that policy requires an ambulance to be summoned if a detainee is of "questionable consciousness." Constable Bes indicated that he made a "judgment call" based on the facts that Mr. Nielsen "...was conscious, he was responding, doing things we asked him to do. At that point I didn't see a need for an ambulance because at that point he was fine, he was breathing, his heart was fine and he was just heavily intoxicated. And possibly with – there's always a possibility of drugs but at that point we don't know."

35. In discussing the policy relating to "questionable consciousness," Constable Bes confirmed that he had read the policy when it was issued but had received no direction or training on how to interpret that phrase.

36. I note that Mr. Haison and Provost Supervisor McKinley are employees engaged by the municipality of Kamloops and, therefore, are not persons "appointed or employed under the authority of [*The RCMP*] *Act*." The Municipal Policing Agreement entered into between the Governments of Canada and British Columbia provides that "[t]he Province shall, or any Municipality may, provide, without any cost to Canada, all necessary Support Staff [Note: this includes

guards and matrons]; such Support Staff shall meet the job and other related requirements as determined by the [RCMP] Commissioner."

37. As Provost Supervisor, Mr. McKinley is responsible for guard training at the Kamloops City RCMP Detachment. The elements of that training regimen are set out below in the section entitled "Relevant Training, Civilian Guards." Mr. Haison confirmed that he had been trained in the manner contemplated by Mr. McKinley's program.

38. At the end of a probationary period consisting of 75 eight hour shifts, a four hour test is administered. After the probationary guard has demonstrated that he meets the standards required, the applicable collective bargaining agreement does not permit further performance reviews.

Observations about the Applicable Operational Policy

Applicable National (Headquarters), Divisional and Detachment Policy respecting the care and treatment of persons in RCMP custody are set out, in full, in Appendix "A" to this Report.

I note the following about the relevant policy in force at the time of the subject incident:

- There is a clear recognition that "the RCMP is responsible for the well-being and protection of persons in its custody." This is a laudable statement of its obligation and a good reflection of current Canadian law on the subject.

- There is a clear recognition that anyone who is "ill, suspected of acute alcohol poisoning or a drug overdose, injured or not fully conscious" is to receive immediate medical treatment and is not to be placed in a cell until found fit for incarceration after a medical examination.

- There is a clear recognition of the need to share information, at least with medical personnel, about the "person's [medical] condition prior to and during the period of care or custody."

- There is a clear recognition, when dealing with alcohol intoxication that "difficulty communicating" is one of the symptoms that requires "medical assistance immediately."

- There is a clear direction that members are to be alert to complaints about illness or injury and if they "have any reason to believe" that medical attention is necessary, they are to arrange it "immediateiy."

Relevant Training

Cadet Training

Cadets receive 22 weeks of training prior to graduation from Depot. Our research indicates that a 33 hour training module (Module VI) is the principal vehicle for delivery of training to Cadets in the area of the care and handling of detainees. The 4 hour session of the module that specifically addresses the care and handling of detainees is described as follows in the Facilitator Guide:

> "Cadets view a video on prisoner escorts and demonstrate and practice placing prisoners in and taking them out of police vehicles. Cadets complete a written exercise on the handling of prisoners. Cadets, then, participate in role plays on escorting prisoners to the cell block and discuss the reasons for search and seizure of effects from a prisoner, including those effects that have a religious meaning. Cadets complete the Prisoner Effects Report C-13-1 and are given a demonstration of photographing a prisoner."

In the course of this 4 hour session, Cadets are provided with a handout that reads as follows:

> **"CARE AND HANDLING OF PRISONERS HANDOUT**
>
> **MEDICAL ATTENTION**
>
> Under RCMP policy, should a prisoner require medical attention, do not allow them any form of medicine unless a doctor has been consulted, except normal doses of common medicines. KEEP RECORD OF DOSES GIVEN. **If there is any indication that a person in your custody is ill, suspected of acute alcohol poisoning or a drug overdose, injured or not fully conscious, even if the person denies same, ensure he/she**
>
> 1. **is examined by a medical practitioner;**
> 2. **receives immediate treatment; and**
> 3. **is not placed in a cell unless a medical examination finds him/her fit to be incarcerated.**
>
> While in the custody of the RCMP, all medical and dental expenses will be paid from public funds."

After distribution of the handout, Cadets are required to complete an eighteen question questionnaire. Arguably, only one of the eighteen questions is designed to test the Cadet's understanding of the policies related to the care and handling of detainees (Appendix "A").

Sergeant Abel made it clear that the emphasis on this area of policy will vary depending on the Instructor. Again, depending on the Instructor, the topic may be broached in the course of other training sessions.

Civilian Guards

As indicated, Mr. McKinley, who is a Kamloops municipal employee, is responsible for providing training to civilian guards engaged in guarding detainees at the Kamloops City RCMP Detachment. In general terms, that training can be described as follows:

- Each new guard must spend 80 hours working with an experienced guard before undertaking guard duties on their own;

- During this time, they must study relevant RCMP policy relating to the guardroom including policy related to emergency procedures and medical procedures;

- At the end of this initial 80 hour training period, Mr. McKinley conducts a review of the trainee's knowledge of job requirements in accordance with a check list that he maintains;

- Over the course of the 75 shift probationary period noted earlier, Mr. McKinley prepares a "New Employee Probationary Assessment" at the end of the twentieth, fortieth and seventy-fifth shift. These assessments are submitted to the City of Kamloops but are available to the RCMP when they conduct their regular guardroom audit (every eight months);

- At the end of the seventy-fifth shift, Mr. McKinley conducts a four hour test of the trainee's knowledge. If he is not satisfied with the demonstrated proficiency, he can apply to the City of Kamloops for an extension of the probationary period; and

- As previously indicated, civilian guards are not subject to regular performance reviews after the successful completion of the probationary period. The only ongoing job requirement is to read relevant portions of RCMP policy every six months.

Following the incident under review, Mr. McKinley developed two tools to better ensure that guards remain current with respect to relevant job knowledge. He now maintains a guard training program log which, among other things, contains information about how to recognize medical problems. He has also instituted weekly "crew talks" that address current concerns and any policy changes.

Our research indicates that, in or about January, 1992, the RCMP Training Directorate approved a Course Training Standard (CL8500) for a Guards Training Course (attached as Appendix "B" to this Report). This course was conceived as a Divisional Course to be delivered by the Divisions as required. Commission staff encountered considerable difficulty in securing a copy of this Course Training Standard which suggests that its existence is not widely known. Mr. McKinley indicated that RCMP authorities had never brought this Course Training Standard for civilian guards to his attention.

The course outline provides for a one and a half day training course covering all areas of guard's responsibilities. The course outline is unclear but it would appear that no more than an hour or two is devoted to the Part of the course entitled "Safeguarding Prisoners." Too short a portion of this Part is devoted to "Emergency Procedures" where, among other things, "ill prisoners" are discussed.

Maricopa County Sheriff's Office

In the course of this investigation, Commission staff had the benefit of consulting Mr. Wayne Jeffery, Head, Toxicology, RCMP Forensic Laboratory. As a toxicologist and certified Drug Recognition Expert (DRE), Mr. Jeffery is an expert in identifying and interpreting the signs and symptoms of alcohol and/or drug use in persons in contact with the RCMP. After being apprised of the nature of the present investigation, he referred Commission staff to the Maricopa County Sheriff's Office (MCSO), an Arizona police agency that has recognized the need for specific training in this crucial area for front-line officers.

MCSO officials made available to the Commission a "Lesson Outline" prepared for use in teaching Recruits and Detention Officers about Sudden In-Custody Death Syndrome (SICDS). This three hour course has been given by the MCSO since 1997.

This course has been designed to ensure that police and detention officers are cognizant of, among other things, the causes of SICDS, the profile of a potential SICDS victim and the role played by drugs and alcohol. The course outline highlights the fact that "[a]ll law enforcement professionals must be thoroughly familiar with SICDS for it's fraught with both criminal and civil liability for the individual officer and the agency." It underscores the fact that this potential civil and criminal liability is engaged because "[t]he officers involved assume the duty to maintain the well-being of the subject."

I note from my review of the outline that the course is not designed to be a specialized first-aid course that would permit the officer being trained to render medical assistance; rather, it is designed to acquaint the officer with the signs and symptoms that indicate that immediate medical assistance is required.

Assessment Aids

Following a consultation with a safety officer employed by the City of Kamloops after Mr. Nielsen's death, Mr. McKinley was supplied with a document entitled "The Glasgow Coma Score" (a copy of the particular document supplied by Mr. McKinley is attached as Appendix "C" to this Report).

The Glasgow Coma Score/or Scale (GCS), first published in 1974,[2] is a standardized system used to assess an individual's degree of consciousness. Though the authors of the GCS identified certain limitations on its use, it is widely regarded because of its simplicity and the ease and reliability with which lay persons can communicate the results.

Since the death of Mr. Nielsen, Mr. McKinley has concluded that it is appropriate to incorporate this document into the guards' training program and he now provides it to every new guard. Though available in the guardroom, it is not presently posted in a conspicuous location for quick reference, especially in an emergency.

A member of the Commission's staff recently attended a conference in London, England that focused on "Medical Aspects of Death in Custody." In the course of the conference, reference was made to a policy introduced by the Metropolitan Police Service (London) in 1997 that has become commonly known as the "4R's of Rousability." A copy of this policy, "Health care of prisoners – 4Rs Observation check list," is attached as Appendix "D" to this Report. This one page document directs the officer to consider symptoms – **R**ousability: can the detainee be wakened; **R**esponse to questions: can the detainee answer simple ones; **R**esponse to commands: can the detainee respond to simple ones – and then to **R**emember to consider other possible complicating factors such as drug intoxication and injury.

Like the Glasgow Coma Score, this policy is a straightforward assessment aid and check list that assists a police officer, or civilian guard, to determine if a detainee is in need of immediate medical attention.

Review of the Scientific Literature

As previously noted, Mr. Leo Walter is in charge of the Toxicology Section, RCMP Lab in Edmonton and is the Acting Chief Scientist for all RCMP Toxicology Labs in Canada. His professional qualifications include a Master of Science Degree in Pharmacology from the University of Alberta. In his discussions with the Commission Investigator, Mr. Walter shared his understanding of advances in the scientific investigation of the risks associated with the ingestion of cocaine, particularly when mixed with alcohol and provided copies of relevant scientific literature.

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[2] Jennett B., Teasdale G., *Assessment of coma and impaired consciousness. A practical scale.* Lancet, 2(872): p. 81-4, 1974.

It has been known for some time in scientific circles that "[r]ecreational cocaine use is associated with stroke, myocardial infarction, and unexpected sudden death in young healthy individuals."[1] It is also well-known, again in scientific circles, that "[a]lcohol is the most frequently abused drug used in combination with cocaine."[2] By 1992, scientific research had established that "...users of alcohol and cocaine who also have coronary artery disease have 21.5 times the risk for sudden death than users of cocaine alone."[3] By the same year, researchers were coming to understand that the mix of alcohol and cocaine forms metabolites that are more toxic than cocaine by itself. This advance explained clinical observations that had long perplexed researchers:

> "Most people who experience cocaine related heart attacks and strokes do so when cocaine levels in their blood are low. 'It is the exception, not the rule, to hear of somebody who takes two lines of cocaine and has a stroke or a heart attack. Most of the time they did their cocaine the night before, or that morning,' Karch [Steven Karch, MD, a cardiac researcher interested in cocaine cardiotoxicity] says.
>
> 'We have seen cases where a person had no cocaine in their blood, only benzoylecgonine (a longer-lasting, inert metabolite of cocaine), and yet they were obviously experiencing cardiotoxicity....' Karch explains."[4]

In short, the cardiotoxic effects of **combined alcohol and cocaine use are known to manifest themselves a substantial time after ingestion of the cocaine and not, as one might intuitively expect, immediately after ingestion.**

As noted earlier, the Maricopa County Sheriff's Office has made a concerted effort to ensure that the toxic effect of an alcohol/cocaine mix is well known to Recruits and Detention Officers to enable them to meet their legal and professional responsibility to members of the public in their custody. In introducing its SICDS course, it is noted that "[t]his condition has been recently thrust into the spot light nation wide by the increase in the deaths of suspects and/or inmates while in the custody of law enforcement personnel." The introduction highlights, for course recipients, the lethal consequences of an alcohol/drug mix where the quantities of each have not reached toxic levels:

> "With over 400 incidents studied, '[m]edical examiners have not been able to ascertain an accurate cause of death during an autopsy. The results in 99% of these autopsies are negative; no cause of death apparent. Even though various types of drugs are present, cocaine, methamphetamine, etc., the amounts found are not consistent with the quantities known to be

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[3] Jerry L. Bauman, PharmD, Jeffrey J. Grawe, PharmD, Allison P. Winecoff, PharmD and Robert J. Hariman, MD. *Cocaine-Related Sudden Cardiac Death: a Hypothesis Correlating Basic Science and Clinical Observations*. J Clin Pharmacol 1994, 34:902-911.

[4] Jeffrey Jentzen, MD, *Medical Complications of Cocaine Abuse*, A.J.C.P. November 1993.

[5] Teri Randall, *Cocaine, Alcohol Mix in Body to Form Even Longer Lasting, More Lethal Drug*, Medical News & Perspectives, JAMA, February 26, 1992 – Vol 267 No 8.

[6] *Ibid.*

> lethal. Alcohol is also often involved, but again not in quantities large enough to be lethal on its own.'"

Mr. Walter, when discussing these relatively recent scientific advances, expressed the view that the toxic potential of an alcohol/cocaine mix hours after ingestion is not a phenomenon well known to most police officers. Clearly, the Maricopa County Sheriff's Office has determined that the dissemination of this information to front-line officers is critical.

Historical Context

As I indicated at the outset, when the circumstances of Mr. Nielsen's death came to my attention, I was concerned by certain historical parallels. Specifically, I was disturbed by the fact that, in previous cases addressed by the Commission, RCMP policy relating to the care and handling of detainees was not well understood, or implemented, by members of the RCMP. To highlight my concerns, following is a brief review of those cases, and the Commissioner's response to this Commission's recommendations.

Robinson/Farewell

In October of 1988, Donald Robinson and four members of his family complained about the conduct of certain members of the RCMP after Mr. Robinson suffered serious injuries while being held in the Gibsons RCMP Detachment in British Columbia. Mr. Robinson had been jailed for excessive drinking and refusing to leave a cabaret. At one point during his incarceration, Mr. Robinson was removed from his cell after assaulting another inmate. A heated discussion ensued between Mr. Robinson and an RCMP officer, resulting in an altercation in which Mr. Robinson sustained undetermined injuries. Both prior to and after that incident, Mr. Robinson, to the knowledge of his custodians, was involved in four other fights with two of his cellmates, thereby making it difficult to assess the damage inflicted by the RCMP officer. Upon his release the following morning, he proceeded to a hospital where he was found to have severe facial contusions and abdominal trauma with internal bleeding that required him to be hospitalized for a number of days.

The Panel of the Commission conducting the hearing concluded in its 1991 Report that the RCMP member who assaulted Mr. Robinson had acted improperly, although it could not identify the precise injuries caused to Mr. Robinson by the member. The Panel was critical of the conduct of the subject members for a number of reasons but, for the purposes of this Report, I will focus on the finding that the subject members improperly failed to ascertain that Mr. Robinson was in need of immediate medical attention.

The Panel recommended, among other things, that an arresting officer be required to note and record an individual's physical condition upon being taken into custody and make frequent observations of the individual during the period of his detention. As well, the Panel recommended that the Officer in Charge of each detachment take steps to ensure that both members and civilian guards have a solid working knowledge of the relevant

portions of the RCMP Operational Manual as well as any detachment supplement dealing with the care and handling of persons in custody. In this respect, the Panel focused on the need for on-going training and periodic testing of members' knowledge. More specifically, the Panel recommended that officers and guards be made aware of the potential symptoms that could be exhibited by an individual combining alcohol or substance abuse with a physical injury.

When replying to the Commission's Interim Report, the Commissioner of the RCMP took the position that Force policy was adequate, but he agreed that the subject members had failed to adhere to it. He further indicated that the Force would examine the need for members and civilian guards to receive additional instruction designed to allow them to recognize symptoms indicative of the need for immediate medical attention.

The Final Report of the Chair on the Robinson/Farewell complaint makes it clear that neither the Chair nor the Panel intended to be critical of existing policy; rather, the Report highlighted the "clear failure in the application of Force policy at the detachment level." The Chair endorsed the training regimen suggested by the Panel and was appreciative of the Commissioner's indication that the Force would consider whether or not "members and civilian guards should receive additional instruction in recognizing the signs and symptoms which indicate the need for medical assessments of or assistance to prisoners."

Wilson

Seven years after the Robinson incident, Donna Wilson, a friend of Robert Keddie, filed a complaint about the conduct of certain members of the RCMP after Mr. Keddie died while being detained in the Whitehorse RCMP Detachment in the Yukon on March 30, 1995. Mr. Keddie had been taken into custody pursuant to the Yukon *Liquor Act* after being found apparently grossly intoxicated in a hotel bar. Despite claims from his friends and others at the hotel that he was prone to seizures and heart attacks (mainly due to excessive use of alcohol), that he was having a heart attack or that he had had a seizure and despite the fact that he could not even walk unassisted, Mr. Keddie was taken into custody and placed in a cell. Ultimately, the cause of his death was found to be a combination of acute morphine overdose and acute alcohol intoxication.

After conducting a hearing, a Panel of the Commission found that the officers who took Mr. Keddie into custody ignored obvious warning signs. (As noted above, I sat on this Panel and, as the Nielsen investigation proceeded, I was struck by the numerous similarities between the physical conditions of Mr. Keddie and Mr. Nielsen.)

The Panel found the officers had insufficient knowledge and training to properly handle intoxicated people and that RCMP policy on this topic was "so voluminous and difficult to access that the officers cannot become knowledgeable and remain current with it." The decision to place Mr. Keddie in a cell without medical attention was severely criticized and the supervision of Mr. Keddie while there was determined to be inadequate.

The Panel recommended, among other things, an improvement in the system by which policy and standards are set; that training be reviewed to ensure that RCMP members are aware of the common symptoms of alcohol and drug overdose; that members receive refresher courses in this area; that a system of monitoring and retesting of first aid qualifications be implemented; that all cells in the Whitehorse Detachment be monitored with closed circuit televisions; that community policing be re-evaluated in the context of drug and alcohol abuse, with a view to partnering with appropriate agencies; that an examination of the requirements and training of civilian guards be undertaken; and that the policy affecting the detention of intoxicated persons be reviewed for clarity and consistency. The Panel found it necessary to repeat certain of the recommendations from the Robinson/Farewell Report. More generally, the Panel suggested that RCMP senior management review and monitor the extent to which the RCMP has implemented the recommendations of the Public Complaints Commission.

The Commissioner of the RCMP agreed with the bulk of the Commission's findings and recommendations and concurred with the conclusion that the officers involved could have interpreted, and reacted differently to, the indicators that were present upon Mr. Keddie's arrest. The Commissioner acknowledged that the subject members apparently lacked up-to-date knowledge of relevant RCMP policy. The Commissioner conceded that the civilian guard had not received adequate training and had not kept proper records on the night in question.

The Commissioner accepted that the various levels of policy should be reviewed with a view to making them consistent. He agreed that all detachments should have round-the-clock access to medical professionals and that every Commanding Officer should ensure that all operational members have first aid qualifications that are maintained current. The Commissioner conceded that some of the Robinson/Farewell recommendations were never implemented.

Although the Commissioner agreed with the bulk of the Panel's recommendations, after I became Chair, I found it necessary, in my Final Report, to reiterate the need for refresher training in the detection of signs of alcohol and drug abuse because the Commissioner had failed to address it in his Notice. Finally, I considered it appropriate to repeat the Panel's recommendations respecting basic training and the dissemination of policy.

Findings

Based on all of the foregoing, I find the following:

1. After receiving the call about Mr. Nielsen, Constable Bes responded quickly and, while in contact with Mr. Nielsen, treated him humanely and with dignity.

2. When Constable Bes attended at the New Life Mission, Mr. Nielsen was uncommunicative and unable to walk.

3. When Constable Bes departed the New Life Mission with Mr. Nielsen in custody, he was unaware that Mr. Peel, who had substantial knowledge about Mr. Nielsen, believed Mr. Nielsen to have suffered a brain injury in the past that resulted in frequent blackouts nor was he aware of Mr. Peel's view that, in his experience, Mr. Nielsen's condition was "strange" and it was the "worst shape" in which Mr. Peel had ever seen Mr. Nielsen. Similarly, Constable Bes was unaware that Mr. Peel knew Mr. Nielsen lived an "addicted lifestyle" and knew him to be involved in the use of drugs.

4. Mr. Nielsen smelled strongly of mouthwash while in the custody of Constable Bes.

5. At the detachment, Mr. Nielsen remained uncommunicative and unable to walk although he made what appeared to be some rudimentary efforts to respond to instructions. I find as a fact that Mr. Nielsen was in a state of "questionable consciousness" from the time Constable Bes attended at the New Life Mission at approximately 10:47 a.m. until he was placed in the cell at approximately 11:05 a.m. Accordingly, pursuant to the relevant RCMP policy, Mr. Nielsen should not have been placed in the cell.

6. When searched, Mr. Nielsen was found to be in possession of two used hypodermic needles, "tracks" were observed on his arms as was a "relative fresh needle mark" (one half hour to twenty four hours old).

7. To an officer or civilian guard properly trained to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion, Mr. Nielsen's inability to communicate, in conjunction with the obvious signs of acute alcohol intoxication, should have indicated the need to secure prompt medical attention for Mr. Nielsen.

8. To an officer or civilian guard properly trained to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion, the evidence of recent drug ingestion (the hypodermic needles in his possession, the "tracks" and the fresh needle mark), in combination with the obvious indicia of acute alcohol intoxication should have indicated the need to secure prompt medical attention for Mr. Nielsen.

9. I note that, if the Glasgow Coma Score had been available to members and guards at the Kamloops Detachment, the highest possible 'Score' that could have been assigned to Mr. Nielsen was 11 in light of the fact that he was incapable of speech at the time of his detention. Immediate medical assistance is necessary if the 'Score' is 13 or less. Similarly, if the "4R's of Rousability" had been available as an assessment aid and check list, it would also have dictated that immediate medical intervention was necessary because Mr. Nielsen was unable to communicate.

10. When Mr. Nielsen was taken into custody by Constable Bes, his blood alcohol reading was in the range of 0.45 milligrams per one hundred millilitres of blood, a degree of intoxication that is life-threatening.

11. Sometime in the hours before his detention, Mr. Nielsen had ingested an unknown amount of cocaine. This is confirmed by the Toxicology Report that indicated the presence of the cocaine metabolite, benzoylecgonine. In making this finding, I want to make it clear that Constable Bes had no reason to know, specifically, that it was cocaine that Mr. Nielsen had ingested one half hour to twenty four hours before his detention.

12. If Mr. Nielsen had received urgent medical attention when detained, which was approximately four hours before his cardiopulmonary arrest, it is possible that he may have survived this episode of acute alcohol intoxication combined with cocaine use.

13. When Mr. Haison discovered that Mr. Nielsen had suffered a cardiopulmonary arrest, no effort was spared by members of the RCMP, or by the civilian guards, to resuscitate him.

14. By the time, Mr. Nielsen had been transported to the Royal Inland Hospital, he had suffered irreversible brain damage.

15. Current RCMP policy properly enunciates the obligation owed by the RCMP to people in their custody.

16. Current RCMP policy provides several useful guidelines for members and civilian guards dealing with persons in Mr. Nielsen's circumstances:

- Obtain immediate medical aid if the person in custody is not fully conscious or is of questionable consciousness;
- Share medical information about a person in custody, at least with medical professionals;
- Recognize difficulty communicating as a symptom that requires immediate medical attention if dealing with alcohol intoxication;
- Be alert to any "clues" that may indicate that a person in custody requires medical attention.

17. The policy in place dealing with medical assistance for detainees at the time of this incident was not well understood nor well implemented by Constable Bes because, as he indicated, when interviewed by the Commission Investigator, the

policy dealing with "questionable consciousness" was made available to him but was not accompanied by any instructions or clarification.

18. Toxicologists in the employ of the RCMP are aware that the use of alcohol in conjunction with other drugs, like cocaine, can be lethal. Those toxicologists are aware that the cardiotoxic effects of combined alcohol and cocaine use are known to manifest themselves a substantial time after ingestion of the cocaine and not immediately after ingestion.

19. The toxic potential of an alcohol/cocaine mix hours after ingestion is not well known to most police officers or civilian guards.

20. On the basis of the information provided to me by the RCMP, I find that Depot does not adequately train Cadets to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion. The result is that RCMP policy dealing with medical assistance for detainees is not likely to be well understood or applied by recruits.

21. Prior to May 21, 1997, the day Mr. Nielsen was found unconscious in his cell, I find civilian guards at the Kamloops City RCMP Detachment were not properly trained to recognize the symptoms of acute alcohol poisoning alone or in combination with drug ingestion, with the result that the RCMP policy dealing with medical assistance for detainees was not well understood or applied.

22. The Course Training Standard (CL8500) for a Guards Training Course is inadequate in the crucial area of assessing the need for medical assistance for detainees. As well, it would appear that the existence of this Course Training Standard is virtually unknown and, therefore, that Divisional use of this Standard, in the manner contemplated by the Commissioner's response to the Robinson/Farewell recommendations respecting civilian guards, was never implemented.

23. In the interests of clarity, I find that responsibility for the care of detainees ultimately remains with the RCMP even when the RCMP, in accordance with a policing agreement, is compelled to employ civilian guards to discharge that RCMP responsibility.

Recommendations

In light of all of the foregoing, I make the following recommendations:

1. Provide training to all operational members, and Cadets, to assist them in recognizing the symptoms of acute alcohol poisoning alone or in combination with drug ingestion in order to better enable them to determine if persons in their custody need immediate medical assistance. Such training should ensure, among other things, that members can use and understand a straightforward assessment aid and check list similar to the Glasgow Coma Score and/or the Metropolitan Police Service policy commonly known as the "4R's of Rousability."

2. The officer in charge of every detachment should ensure that all civilian guards are given access to training of the type contemplated above.

3. Post a straightforward assessment aid and check list similar to the Glasgow Coma Score and/or the Metropolitan Police Service policy commonly known as the "4R's of Rousability" in a conspicuous location in the guardroom and/or the booking area of every detachment.

4. When taking custody of a person who is apparently intoxicated, members should obtain, record and share with other members and civilian guards, as necessary, all information available from persons having knowledge of the circumstances of the detainee. For example, members should attempt to identify the intoxicant[s] involved, any history of illness or injury and any other information reasonably relevant to a determination of whether or not the detainee requires immediate medical attention.

5. Ensure that all members and civilian guards have a solid and continuing knowledge and understanding of the operational policy dealing with medical assistance for detainees.

6. Ensure that all members and civilian guards are regularly reminded that any doubt about the need for immediate medical attention for a detainee is to be resolved in favour of obtaining immediate medical attention.

7. Ensure that information available to the RCMP, like recent advances in the understanding of the lethal consequences of an alcohol/cocaine mix, is effectively communicated to operational members on an organized and regular basis.

8. Ensure that every detachment designates a non-commissioned officer who is specifically charged with ensuring that civilian guards responsible for RCMP detainees are capable of undertaking the care and custody of detainees in accordance with all relevant RCMP policy.

I hereby submit my Report in accordance with the terms of subsection 45.43(3) of the *RCMP Act* this 17th day of February, 2000.

Chair

February 17, 2000

Shirley Heafey
Chair
RCMP Public Complaints Commission
P.O. Box 3423, Station "D"
Ottawa, Ontario K1P 6L4

APPENDIX A

APPENDIX A

The relevant National (Headquarters) Policy, found in the Operational Manual, Part III, Chapter 3 and bearing revision date 96-07-10, reads as follows:

3. PRISONERS AND MENTALLY DISTURBED PERSONS

A. SUBJECT

1. This chapter deals with the guarding, handling, processing, and care of prisoners and mentally disturbed persons.

C. POLICY

1. A person in RCMP custody will be treated with decency and provided with all the rights accorded to him/her by law.

D. GENERAL

3. If serious injury or death occurs to a prisoner or person being arrested or in RCMP custody/care, an independent investigation will be immediately conducted by a qualified senior investigator.

E. PERSONS IN CUSTODY

1. General

    a. The RCMP is responsible for the well-being and protection of persons in its custody.

2. Medical Treatment

    a. If there is any indication that a person in your custody is ill, suspected of acute alcohol poisoning or a drug overdose, injured or not fully conscious, even if the person denies same, ensure that he/she:

1. is examined by a qualified medical practitioner;
2. receives immediate medical treatment; and
3. is not placed in a cell unless a medical examination finds him/her fit to be incarcerated.

The relevant Division Policy, bearing revision date 90-05-04, reads as follows:

5. MEDICAL TREATMENT

a. General

1. If there is any indication that a person in the care or custody of the RCMP is sick or injured, immediately obtain medical aid. HQ Ops. Man. III.3.C.12 & 13. and III.3.E.3. refer.

2. A member who suspects that a person in custody may be sick or injured will make comments respecting that illness or injury in the "remarks" portion of the Prisoner Record, Form C-13-1, and on the reverse side of the form if additional room is required.

3. When a person is taken to a hospital or medical facility, ensure that the doctor or medical practitioner receives all information relative to:

1. any known or suspected illness or injury; and
2. the person's condition prior to and during the period of care or custody.

4. When arresting a person at a hospital or other medical facility, consult with the attending physician, if available, or other senior medical staff, and establish the person's medical condition.

1. Ensure that the individual's condition does not require further immediate treatment or preclude incarceration.

b. Questionable Consciousness.

1. A person who is ill, injured, unconscious or of questionable consciousness at the time of arrest shall not be placed in a cell UNLESS medically examined and found fit to be incarcerated.

2. Questionable Consciousness means:

1. a person is either conscious or questionable. If questionable, medical attention is needed immediately. Members will not attempt to determine the degree of consciousness of a person who appears to be less than fully conscious.

3. Chronic Alcoholics

1. Chronic alcoholics may suffer from Subdural Hematoma (hemorrhage of the brain or bleeding of the brain, between it and the skull). This condition is caused by a deterioration of the blood vessels due to the abuse of alcohol and can be set off by a slight blow to the head.

2. Members should familiarize themselves with symptoms related to Subdural Hematoma as early medical treatment could prevent a needless death. Symptoms are recognized in persons who:

   - cannot easily be aroused from sleep; have difficulty communicating
   - are drowsy; or
   - have little or no reaction to parts of their body.

3. Seek medical assistance immediately when dealing with alcoholics who have been involved in fights, motor vehicle accidents or other incidents, and show any of the noted symptoms.

Relevant Detachment Policy, found in the Kamloops Detachment Operational Unit Supplement and bearing revision date 95-03-13 reads as follows:

III.3 PRISONERS AND MENTALLY DISTURBED PERSONS

A. SUBJECT

1. This chapter deals with the handling of prisoners and mentally challenged people at Kamloops City Detachment.

D. GENERAL

1. We are responsible for the safety and well-being of everyone in custody.

2. A person who is ill, injured or of questionable consciousness at the time of arrest will not be placed in a cell unless medically examined and found fit to be incarcerated by a qualified medical practitioner.

3. Whenever you have a concern as to the state of health or well-being of a person being arrested or who is already in RCMP cells, immediately seek medical aid for that person.

G. HANDLING OF PRISONERS

1. Security

b. Watch NCO (or his delegate) will:

xi) Be cognizant of injuries or illness suffered by a prisoner. If a prisoner complains of illness or you have any reason to believe a prisoner needs medical attention, arrange medical examination by a doctor immediately. Either have a doctor attend the cells or escort the prisoner to the hospital. A prisoner in custody for intoxication only can be booked out and need not be guarded at the hospital.

c. Guards will:

i) Ensure that they have read and are familiar with the following policies:

- Kamloops Detachment Unit Supplements
- Ops Manual Chapter III.3.E.4., III.3.F.1. and III.3.F.3.

ii) Check all prisoners under their care and supervision to ensure the safety and well-being of all prisoners....

xii) Will report any serious problem or irregularity concerning the security or health of prisoners immediately, by either sounding the panic alarm or by immediately notifying the Watch Commander on duty. Should a prisoner complain of illness or should you have any cause to believe he/she is ill, it is to be immediately brought to the attention of the Watch Commander.

3. Medical Treatment/Examination

a. Medical Treatment

i) Persons visibly ill or injured when arrested may be taken to the Kamloops "Walk-in Clinic" during their normal working hours, 0900 - 2100 furs. Persons who appear severely injured or sick or persons who become sick in the Detachment cells are to be taken to the Royal Inland Hospital Emergency Ward.

APPENDIX B

APPENDIX B

File Number: GTD-570-180-CTS
Code Number: CL8500

Headquarters -Ottawa
January 1992

APPROVED BY:

_____

Officer in Charge,
Training Program Development Branch/

COURSE TRAINING STANDARD

GUARDS TRAINING COURSE

Nota : La version française est disponible sur demande.

GUARDS TRAINING COURSE

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PART I

INTRODUCTION AND SYLLABUS

GUARDS TRAINING COURSE

PART I

INTRODUCTION

HOW TO USE THIS DOCUMENT (CTS)

Part I - Should be used by Administrative and Personnel Officers, Line Officers, Training Personnel and Unit Commanders to:

- get an overview of the courses
- select course candidates;
- follow-up member's training; and
- submit course amendments.

Part II - Should be used by Course Co-ordinators, Resource persons, or Training personnel to provide the basis for:

- identifying resource persons;
- discussing session objectives;
- preparing lesson plans;
- developing tests; and
- critiquing sessions and course.

Part III - Should be used by the Course Co-ordinators and/or resource persons for:

- resource material and specific instructions for the efficient conduct of the course (if applicable),

PURPOSE OF COURSE

This course is designed to teach the skills and provide the knowledge needed to be guards at R.C.M.P. cells. Graduates of this course will be able to:

- be familiar with their working environment;
- apply appropriate policy and procedures in the care, handling and safeguarding of prisoners;
- use emergency equipment efficiently and effectively
- handle emergency situations;
- check un-occupied cells;
- book prisoners;
- safely conduct searches of prisoners in accordance with policy;
- apply appropriate precautions in dealing with prisoners in a variety of conditions; and
- consider all implications of "persons in authority" and "threats and promises" as it relates to the rules of admissibility of evidence.

GUARDS TRAINING COURSE

CANDIDATE SELECTION CRITERIA

Candidates for this course should be persons who are employed or are about to be employed as prison guards at RCMP cells. A First-Aid certificate is desirable, but not compulsory.

COURSE

This is a 1½ day Divisional Course designed to be presented by a Detachment Commander or his delegate, wherever guards are employed or about to be employed by the Force. The demonstration/performance method of instruction should be used.

COURSE EVALUATION

Course Amendments may result from formal or informal feedback.

Formal Feedback:

Our courses are formally evaluated in three ways:

1. Pilot Evaluation - the pilot running of a new or substantially revised course is evaluated to detect and resolve course-related problems at the outset;

2. Formative Evaluation - subsequent course runnings are monitored through the use of formative evaluation forms completed by course participants during and/or at the end of a course as directed by the course co-ordinator; and

3. Summative Evaluation - the effect of training on job performance is assessed through the implementation of the Evaluation Plan included in Part III of this Course Training Standard.

Informal Feedback:

Informal feedback is invited from all members to inform us of changes in administrative procedures and operational duties and responsibilities. When training requirements change, the training provided must be adjusted accordingly. Please forward comments and suggestions through regular channels to:

The Commissioner

Attention: Officer in Charge
Program Development Branch

COURSE	GUARDS TRAINING COURSE				
HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
08:00	ORIENTATION	AWARENESS OF POTENTIAL DANGER AND LEGAL IMPLICATIONS			
08:30	DETACHMENT FAMILIARIZATION				
10:00	FORMS FAMILIARIZATION	STATUTE POWERS LIMITATIONS AND OBLIGATIONS			
11:00	SAFEGUARDING PRISONERS	COURSE EVALUATION			
LUNCH	12:00	12:00	12:00	12:00	12:00
13:00	(CONTINUED)				
14:00	SEARCHING PRISONERS				

PART II

COURSE TOPIC PAGES

GUARDS TRAINING COURSE

PART II

COURSE ORIENTATION

Course candidates complete courses according to requirements.

This session is designed to welcome candidates to the course, set an atmosphere which encourages learning and to provide the candidates with an overview of the course. The session is to be given by the course co-ordinator or manager as it will provide an opportunity for the candidates and course manager to become familiar with each other. A short opening address welcoming candidates to the course by a person of authority will give credence to the importance of the course.

An excellent method of "breaking the ice" is to have the candidates introduce themselves or another candidate to the rest of the class. These introductions usually include a few details about the individual and a few words about what they hope to gain from the course.

The course co-ordinator should encourage the candidates to take this opportunity to ask questions on any aspect of the course they may not understand. It is essential that each candidate has a clear understanding of the course material, procedures and especially the course objectives before the actual instruction begins.

Setting the "right" atmosphere and motivating the candidates to learn can not be overemphasized.

- opening address
- mutual introductions
- course
    - purpose (job relevancy)
    - syllabus
    - objectives
    - course material
    - testing and assessment procedures
    - pilot course evaluation procedures (if applicable)
    - evaluation procedures
    - teaching method (lecture, I.I., etc.)
    - evening classes and assignments
    - miscellaneous
    - administration
    - accommodation
    - meals and coffee
    - transportation
    - expenses
        - deportment

GUARDS TRAINING COURSE

PART II

COURSE ORIENTATION (CONTD.)

AT THE END OF THIS SESSION, EACH CANDIDATE WILL BE ABLE TO:

1) EXPLAIN THE PURPOSE OF THE COURSE;

2) OUTLINE THE COURSE OBJECTIVES;

3) INTERPRET THE COURSE SYLLABUS AND EXPLAIN CANDIDATE RESPONSIBILITY AND REQUIRED ACTIVITY FOR EACH SESSION;

4) EXPLAIN THE TESTING AND ASSESSMENT PROCEDURES USED ON THE COURSE; AND

5) EXPLAIN THE COURSE EVALUATION PROCEDURES.

References:

- The Training Manual
- The Systems Approach to Research, Design and Delivery Course

Cross -References:

- Course Evaluation
- Evaluation Plan

GUARDS TRAINING COURSE

PART II

DETACHMENT FAMILIARIZATION

Guards use their knowledge of their working environment in the day to day performance of their duties.

This session is designed to ensure Guards are familiar with the physical lay-out of the Detachment and pertinent equipment/supplies, personnel and policies. Instruction/ demonstration will consist of an orientation tour of the Detachment (and or cell block) with emphasis on items of particular relevance to your detachment.

Location of Emergency Equipment
- fire alarms and fire fighting equipment
- telephones and emergency phone numbers

Cell Block Area
- cells; types and uses
- cell block and cell keys
- booking area
- security lockers for prisoners' effects
- closed circuit TV (if applicable)

Other Areas
- communication center including CPIC
- supplies (stationery and cleaning, etc.)

Procedures/Policy
- shift procedures
- confidentiality requirements
- pay procedures
- Ops. Man III.3 Division and Unit Supplements

AT THE END OF THIS SESSION, EACH CANDIDATE WILL BE ABLE TO:

1) LOCATE AND EXPLAIN HOW TO CORRECTLY USE ALL OF THE EMERGENCY EQUIPMENT LOCATED IN THE DETACHMENT/CELL BLOCK AREA.

2) EXPLAIN THE RELEVANT POLICY, INSTRUCTIONS AND PROCEDURES REGARDING SHIFTS, CONFIDENTIALITY AND PAY.

3) EXPLAIN THE LAY-OUT OF THE DETACHMENT/CELL BLOCK AREA AND WHERE TO FIND LOCKERS, SUPPLIES AND OTHER EQUIPMENT.

GUARDS TRAINING COURSE

PART II

FORMS FAMILIARIZATION

Guards complete or partially complete various Detachment forms.

During this session, Guards will be exposed to the various forms they will be expected to use in connection with their Guard Room duties. A demonstration/ performance type of instruction should be used to ensure trainees will have no difficulty completing the forms later on their own. As a further means to ensure retention of the instruction given in this session, trainees should be given the basic reasons for the required information on the following forms. (NB: Add any other relevant forms not listed below.

- C13-2
- visitor records
- record of prisoner checks
- F 16 (prisoner's meals)
- prisoner/days statement
- guards' time sheets

AT THE END OF THIS SESSION EACH STUDENT WILL BE ABLE TO:

1) GIVEN ANY OF THE ABOVE FORMS AND PERTINENT CIRCUMSTANCES, COMPLETE THE FORM SO THAT ALL REQUIRED INFORMATION HAS BEEN RECORDED.

References:

GUARDS TRAINING COURSE

PART II

SAFEGUARDING PRISONERS

Guards safeguard prisoners.

This session is designed to give Guards all the basic knowledge and skills required to safeguard prisoners under their charge. Throughout this session Guards must be made fully aware that safeguarding prisoners is their primary responsibility. Emphasis will be placed on a complete explanation of relevant Operational Manual policy, Division and Unit Supplements. Prisoner searches should be dealt with superficially at this point as an in-depth session will follow.

Developmental method instruction, demonstration/performance and case studies will include:

Routine Duties/Procedures

- thorough check of cells before and after occupancy
- thorough check of prisoners at intervals specified by policy and procedures
- check of cells and fixtures as well as prisoners (torn blankets, broken bed slats)
- booking and release procedures
- preparation of escort
- meal orders and feeding prisoners including prohibited articles
- exercise periods (where applicable)
- visitors and visiting hours, including incoming material from visitors
- prisoner searches
- security of prisoner effects
- prisoners' use of phone
- smoking in cells
- reading material
- (young offender) prisoner concerns
- operation of closed circuit TV (if applicable)

Emergency Procedures

- fire (local fire orders)
- escape or attempted escape
- attempted suicide
- damage to cells - lights burned out, etc.
- ill prisoners
- trouble in cells (fights in holding areas)
- detachment contingency plans
- local concerns

GUARDS TRAINING COURSE

PART II

SAFEGUARDING PRISONERS (CONTD.)

AT THE END OF THIS SESSION, EACH CANDIDATE WILL BE ABLE TO:

1) GIVEN AN UNOCCUPIED CELL, CHECK THAT CELL "BEFORE OCCUPANCY" AND "AFTER OCCUPANCY" AND IDENTIFY ANY DISCREPANCIES/DEFICIENCIES.

2) GIVEN AN INCOMING PRISONER, BOOK THE PRISONER INTO THE CELL BLOCK COVERING ALL ASPECTS OF THE BOOKING PROCEDURE INCLUDING PROVIDING SECURITY FOR THE PRISONER'S EFFECTS.

3) BRIEFLY EXPLAIN ALL THE PRINCIPAL PROCEDURES INCLUDING THE CARE, HANDLING AND SAFEGUARDING OF PRISONERS IN ACCORDANCE WITH LOCAL POLICY AND ORDERS.

4) GIVEN THE CIRCUMSTANCES OF A HYPOTHETICAL EMERGENCY IN THE CELL BLOCK, OUTLINE ALL THE PRINCIPAL STEPS REQUIRED TO DEAL WITH THAT EMERGENCY.

References:

GUARDS TRAINING COURSE

PART II
SEARCHING PRISONERS

Guards search prisoners.

Normally, members will search prisoners in the cell block; however on occasion a guard may be required to search a prisoner who is of the opposite sex to the arresting member. Although the arresting member will be near at hand during searches, he/she will not be able to see a strip search taking place; therefore each guard must be trained on how to conduct a thorough body and clothing search safely. Furthermore, each guard should be completely familiar with the types of articles and drugs which prisoners would likely conceal. Throughout the session, emphasis must be places on the necessity of thoroughness and safety.

Demonstration/performance method of instruction and audiovisual aids (see reference below) will include:

- Policy on searching prisoners including
  - of opposite sex
  - internal searches

- Searching techniques including
  - items frequently concealed, e.g. drugs and weapons
  - thorough systematic approach
    - top to bottom
    - grabbing and squeezing clothing

- Key areas of concealment including
  - hair
  - collar
  - waistline
  - groin
  - footwear

- Techniques for searching female prisoners (Guard)

AT THE END OF THIS SESSION EACH CANDIDATE WILL BE ABLE TO:

1) IN A ROLE-PLAY SITUATION, GIVEN A "PRISONER" OF THE SAME SEX WHO IS CONCEALING ONE OR MORE PROHIBITIVE ARTICLES ON HIS/HER PERSON:

   A) SEARCH THAT PRISONER IN ACCORDANCE WITH SEARCHING TECHNIQUES APPROVED BY THE FORCE; AND

   B) RETRIEVE THE PROHIBITIVE ARTICLE(S) WITHOUT EXPOSING HIMSELF/HERSELF UNNECESSARILY TO DANGER OF ATTACK BY THE "PRISONER."

GUARDS TRAINING COURSE

PART II

SEARCHING PRISONERS (CONT'D)

References:

- Operational Manual II.12
- I.A.C.P. Training Key No. 9 "Searching Arrested Persons"
- Video Cassette on "Searching Female suspects" (available from Sub/Division in VHS only)
- Training video cassette "Searching Techniques"

PART II

AWARENESS OF POTENTIAL DANGERS AND LEGAL IMPLICATIONS

Guards take precautions to ensure personal safety and compliance with the law.

During this session emphasis should be placed on how vulnerable guards can be should they become too complacent in their duties. Also, they must be fully aware that their very contact with prisoners can result in their being called as witnesses in prosecutions against prisoners. Persons in authority, threats and promises and voluntary statements, and the need for notes should be dealt with briefly.

Developmental method of instruction, case studies and role-plays will include:

- potential danger from prisoners, including hostage situations
- safe areas in cell block during checks
- guarding against being duped by prisoners feigning sickness, casual conversation, etc.
- false sense of security from seemingly docile prisoners
- extra precautions dealing with mental patients and intoxicated persons
- potential danger from visitors and possibility of articles passed to prisoner:
- thorough checks of prisoners arriving on escort and discussion with escort as to problems, etc.
- identification of prisoners to ensure right one released after court, sobering up and that no further "wants" are registered.
- local concerns
- "persons in authority" threats and promises
- voluntary statements and the need for notes
- limiting number of persons who come in contact with a prisoner prior to interview

GUARDS TRAINING COURSE

PART II

AWARENESS OF POTENTIAL
DANGERS AND LEGAL IMPLICATIONS (CONTD.)

AT THE END OF THIS SESSION EACH CANDIDATE WILL BE ABLE TO:

1) GIVEN A SERIES OF CIRCUMSTANCES INVOLVING PRISONER/MENTAL PATIENT BEHAVIOUR WHICH PRESENT RISK TO GUARD SAFETY, OUTLINE ALL THE MAJOR PRECAUTIONS HE/SHE SHOULD TAKE TO MINIMIZE THOSE RISKS. CIRCUMSTANCES SHOULD INCLUDE:

   i) POTENTIAL HOSTAGE SITUATIONS;

   ii) PRISONER(S) FEIGNING ILLNESS;

   iii) SEEMINGLY DOCILE PRISONER(S) BECOMING UNRULY;

   iv) DISTURBED MENTAL PATIENT/OBNOXIOUS INTOXICATED PRISONER(S);

   v) PRISONER/ESCORT ARRIVAL;

   vi) PRISONER/VISITOR CONTACT; AND

   vii) PRISONER RELEASE.

References:

- Operational Manual, Division and Unit Supplements
- Criminal Code

GUARDS TRAINING COURSE

PART II
STATUTE POWERS, LIMITATIONS AND OBLIGATIONS

Guards apply statute powers, limitations and obligations as defined by law.

Guards may be called upon to assist members in subduing violent prisoners and preventing escapes. Also, they may be responsible for ensuring prisoner's legal rights are not unnecessarily denied nor impeded. Therefore, this session is designed to ensure Guards are very clear about their power of (authority), limitations and obligations under the statute and civil law.

Lecture and developmental method of instruction will cover:

- Prisoner Right to Telephone (OM III.3.C.1 & 2.)
- Authority to Use Force and limitations (Section 25 CC)
- Liability for Using Excessive Force
  - criminally (Section 26 CC)
  - civilly
- When Reasonable Force Is Justified (Section 27 CC)
- Sections (7 through 10) of the Canadian Charter of Rights and Freedoms.

AT THE END OF THIS SESSION, EACH CANDIDATE WILL BE ABLE TO:

1) EXPLAIN THE ENTITLEMENT A PRISONER HAS IN HAVING ACCESS TO A TELEPHONE IN ACCORDANCE WITH OM III .3.C.1 & 2.

2) BRIEFLY EXPLAIN:

   i) THE LIMITATIONS OF THE AUTHORITY GRANTED TO HIM/HER UNDER THE PROVISIONS OF SECTION 25 OF THE CRIMINAL CODE;

   ii) THE CONSEQUENCES OF USING EXCESSIVE FORCE TO RESTRAIN A PRISONER AS STIPULATED IN SECTION 26 OF THE CC;

   iii) WHEN REASONABLE FORCE CAN BE USED IN ACCORDANCE WITH SECTION 27 CC; AND

   iv) THE LEGAL RIGHTS OF EVERYONE AS DEFINED IN SECTIONS 7 TO 10 OF THE CHARTER OF RIGHTS AND FREEDOMS.

References:
- Operational Manual, Division and Unit Supplements
- Criminal Code

GUARDS TRAINING COURSE

PART II

COURSE EVALUATION

Candidates provide feedback on the efficiency and effectiveness of the course.

In the case of established courses, continual monitoring is required to detect problems as they arise. In this way, we ensure that training continues to reflect job related needs. It is the responsibility of the course co-ordinator to schedule sufficient time and objective personnel to implement the assessment process. Moreover, it is the course co-ordinator's responsibility to emphasize the importance of honest and accurate completion of forms and to clarify procedures when necessary.

It is the responsibility of the candidate to discuss frankly the training during scheduled course assessment sessions and to complete the following forms:

1. Session Assessment (2114)
2. Course Assessment (2113)

Admin. Man. II.II.T. requires that only Course Assessments be completed and the End of Course Report be submitted on every course. The Session Assessment and the Summary of Session Assessment forms need only be completed if requested by the Course Co-ordinator, Training Supervisor or Training Program Development Branch when they deem more specific data are warranted.

The End of Course Report is a compilation of Course Assessment forms and reflects the candidates' and course co-ordinator's assessments of the course with respect to:

a) need;
b) timing;
c) initial content known;
d) level of presentations;
e) method of presentation; and
f) usefulness.

Moreover, the co-ordinator is required to comment on whether:

1. the selection criteria have been met;

2. it was necessary to deviate from the CTS when the course was given; and

3. whether changes to the CTS are recommended.

Finally, any additional comments or suggestions which would further serve to clarify any problems with the course are encouraged and should be forwarded by the co-ordinator with the forms.

GUARDS TRAINING COURSE

PART II

COURSE EVALUATION (CONTD.)

In the case of a new or substantially revised course, a pilot course evaluation questionnaire is developed by the Training Evaluation Section in consultation with course designers to address specific concerns about course design. This ensures that problems are identified at the outset and resolved before they become serious. It is the responsibility of the course co-ordinator to administer the pilot evaluation questionnaires following the procedures provided and to submit them to the Training Evaluation Section.

The standard formative evaluation forms should not be completed during the initial presentation of a pilot course. However, the course co-ordinator should submit an End of Course Report, reporting his opinions only and, if necessary, should attach additional documentation.

It is the responsibility of the candidate to fill in the pilot evaluation questionnaire as honestly as possible to ensure that the highest possible standard of training is maintained.

PART III

SPECIAL INSTRUCTIONS

GUARDS TRAINING COURSE

PART III

EVALUATION PLAN

In order to determine whether training is achieving its objectives of improving or maintaining a standard of job performance, the Training Evaluation Section conducts summative evaluations. Such evaluations are only initiated when problems associated with the training are identified through formative evaluations, field personnel, the policy center or if directed by the OIC Training Program Development Branch.

Indicators

Indicators of effectiveness are identified when a course is designed. The indicators of effectiveness for the Guards Training Course are:

1. The number of incidents which require a guard's intervention, i.e. prisoner needs medical attention, attempted escape, etc. and the manner in which they were handled.

2. The quality and effectiveness of training received.

Information will be collected through an analysis of data available at or through the policy center and via checklists and questionnaires completed by course graduates and their supervisors.

Sample

A random sample of 25 course graduates who have completed the course within the last three years and their supervisors. The sample will come from all divisions and will be proportionate, i.e. those divisions where more guards are employed will, relative to the other divisions, have a larger number in the overall sample.

Analysis and Report

Training Evaluation Section will analyze the data using the following techniques:

- percentages,
- measures of central tendency, and
- cross tabulations.

A report with recommendations will be issued to all interested parties for discussion. Action will be documented and required changes will be incorporated into this Course Training Standard.

APPENDIX C

APPENDIX C

THIS IS THE GLASGOW COMA SCORE

REPORT THE SCORE WHEN CALLING FOR MEDICAL ASSISTANCE. CALL MEDICAL ASSISTANCE IF THE SCORE IS 13 OR LESS

TABLE III-c

GLASGOW COMA SCORE

EYE OPENING

Spontaneous	4
To Voice	3
To Pain	2
None	1

MOTOR RESPONSE

Obeys Commands	6
Localizes to Pain	5
Withdrawal to Pain	5
Decorticate Response (Flexion)	3
Decorticate Response (Extensor)	2
No Response	1

VERBAL RESPONSE

Normal	5
Confused but Coherent	4
Simple Inappropriate Words	3
Incomprehensible Speech	2
No Speech	1

TOTAL

Highest Possible Score is 15
Lowest Possible Score is 3

THIS IS DECEREBRATE POSITIONING

NOTE HOW HANDS AND FEET ARE EXTENDED

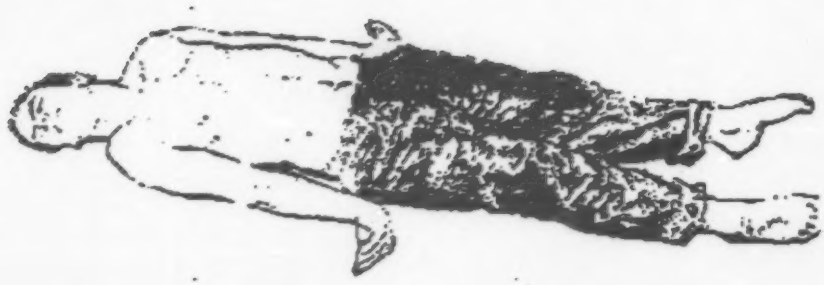
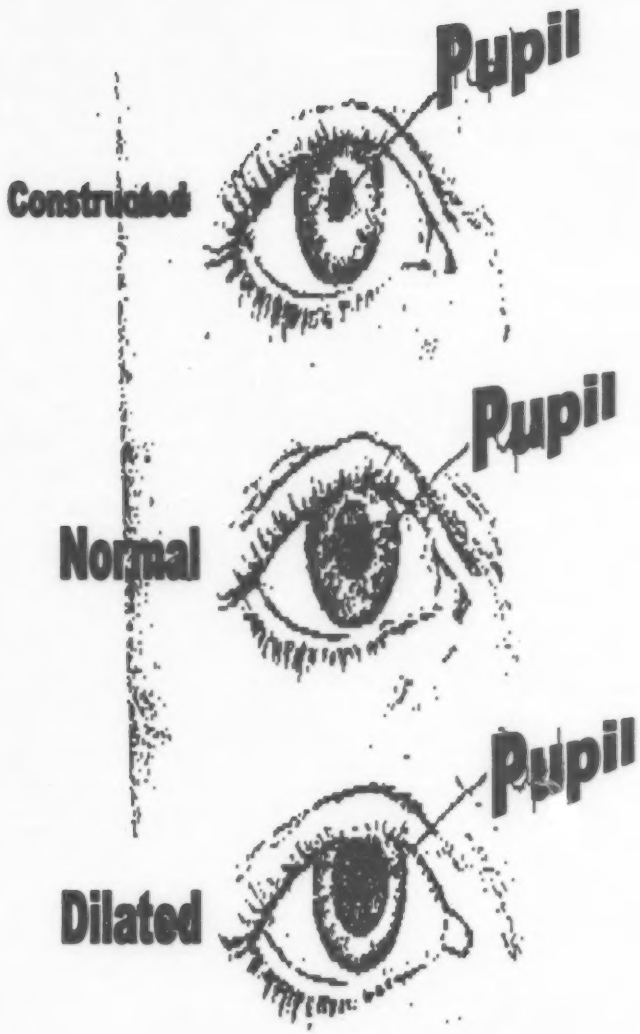


Figure III-5 Decorticate posturing

WITH DECORTICATE RESPONSE, THE HANDS AND FEET ARE FLEXED.

CHECK PUPIL REACTION AND REPORT YOUR FINDINGS WHEN CALLING MEDICAL ASSISTANCE



PUPIL REACTION

APPENDIX D

APPENDIX D

Health care of prisoners
4Rs Observation check list

If any prisoner falls to meet any of the following criteria, a F.M.E. or Ambulance MUST be called when assessing the level of rousability, consider:

Rousability – can they be woken?

- Go into the cell
- Call their name
- Shake gently

Response to questions can they give appropriate answers to questions such as:

- What's your name?
- Where do you live?
- Where do you think you are?

Response to commands – can they respond appropriately to commands such as:

- Open your eyes!
- Lift one arm, now the other arm!

Remember – take into account the possibility or presence of other illnesses, injury, or mental condition.

A person who is drowsy and smells of alcohol may also have the following:

- Diabetes
- Epilepsy
- Head injury
- Drug intoxication or overdose
- Stroke

IF IN DOUBT CALL AN AMBULANCE

28 NOVEMBER 1997